Nebraska
HIV/AIDS Housing Plan

Appendices

October 2003

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Appendix I: Steering Committee Meeting Minutes

Minutes from each Steering Committee meeting held as part of the HIV/AIDS housing planning process are included in this section.

February 27, 2003

Committee Members Present:

Name	Affiliation
Becky Aboushady	*PWA*
Diane K. Adams	*Lexington Housing Authority, Lexington*
Theresa Christensen	*Salvation Army, Omaha*
Leslie Clark	*UNO MPA Grad Student*
Heather Cline-Ford	*Central NE Community Services, Grand Island*
Daniel Cobos	*UNMC, Omaha*
Pat Compton	*NE Dept. of Econ. Dev. Housing/Special Needs, Kearney*
Joseph Conrad	*NAP, Omaha*
Becky Diercks	*Community Action Partnership of Mid Nebraska, Kearney*
Steve French	*NAP Volunteer*
Steve Gable	*NRRC – NAPWA – PACT – PWA – NAP Volunteer*
Dana Grisham	*Community Alliance, Omaha*
Gary Henderson	*Self*
Dennis Hoffman	*Centerpointe, Lincoln*
Judy Hughes-Anderson	*NHHS, Lincoln*
Sandy Klocke	*NHHS, Lincoln*
William R. Mann	*NAP Volunteer*
Tom Maxson	*South Central Behavioral Services, Kearney*
Janet Oberhauser	*CPG Northern Region*
Amy Ondrak	*NRRC*
Paulette Pool	*Hastings Housing Authority, Hastings*
Erin Porterfield	*NAP, Omaha*
Mike Saklar	*Siena/Francis House, Omaha*
Bradd Schmeichel	*Urban Development/Community Planning, Lincoln*
Dean Settle	*Community Mental Health Center of Lancaster County, Lincoln*
T.J. Seward	*NAP, Omaha*
Ron Snell	*Lincoln Connection, North Platte*
Tim Sullivan	*NAP, Omaha*
David Traster	*People's City Mission, Lincoln*
Cindy White	*NRRC*
Elaine B. Wiseman	*Kearney Housing Agency, Kearney*

Liz Wall and Randall Russell, *AIDS Housing of Washington*

Welcome and Introductions

Sandy Klocke, Program Administrator, HIV Program, Nebraska Health and Human Services System, welcomed Steering Committee members and provided an overview of the process that led the state to initiate a statewide assessment of the housing needs of people living with HIV/AIDS in Nebraska. Sandy then introduced Liz Wall, Planning Manager at AIDS Housing of Washington (AHW), and Randall Russell, Consultant to AHW, who are facilitating the needs assessment. AHW is a Seattle-based nonprofit organization that develops housing for people living with AIDS in Seattle and provides technical assistance nationwide.

Meeting participants were asked to introduce themselves and share their reason for attending the meeting. Various reasons were mentioned including: currently working to address the housing-related needs of low-income people, including those living with HIV/AIDS and other special needs, representing agency, received an invitation to participate, and commitment and passion about the issue.

The Context of AIDS Housing Nationally and Locally

Liz Wall and Randall Russell presented information about the context of HIV/AIDS housing nationally and in Nebraska. Information was presented about HIV/AIDS, housing affordability, supportive housing, and the housing needs of people living with HIV/AIDS. Handouts from the presentation are attached.

Services for People Living with HIV/AIDS in Nebraska

Judy Hughes-Anderson, Nebraska Health and Human Services System, and Erin Porterfield, Nebraska AIDS Project, presented an overview of the resources and services available to people living with HIV/AIDS in Nebraska. Judy provided basic information about the Ryan White Program, which funds HIV/AIDS care and treatment, and the role the state plays in funding HIV/AIDS services. Erin summarized the mission of the Nebraska AIDS Project, which is the primary AIDS service agency in the state, and the services provided through Nebraska AIDS Project's offices throughout the state. Handouts from the presentation are attached.

Components of Community-Based Planning

Liz Wall provided a brief explanation of the components of the HIV/AIDS housing needs assessment and indicated that the work of this needs assessment will build on the foundation of the 2002 data gathering process. The current needs assessment process will include five discrete activities that are described below.

- **Steering Committee:** The committee will provide guidance and oversight for the needs assessment process, identify critical issues based on the findings of the needs assessment, and develop strategies to address those critical issues.
- **Consumer Survey:** During the 2002 data gathering process, 215 people living with HIV/AIDS completed a survey about their living situation and housing needs. Results from this survey will be included in the HIV/AIDS housing plan.
- **Focus Groups:** People living with HIV/AIDS will participate in focus groups to discuss their housing needs, providing depth and texture to the data gathered through the survey. Phone interviews will be conducted if necessary to allow participation of individuals who do not live in areas where focus groups will be conducted.
- **Key Informants:** Key stakeholders in fields related to HIV/AIDS housing will be interviewed, including those working in HIV/AIDS services, affordable housing, mental health, substance use treatment, and homeless services.

- **Research:** Existing data related to population demographics, housing, homelessness, HIV/AIDS epidemiology, and dedicated HIV/AIDS housing resources will be summarized and presented.

Community Participation in Needs Assessment

Steering Committee members were separated into three groups: one focused on housing, one on services, and one on HIV. Each group was asked to review the list of key informants and identify additional individuals and organizations that should be included in the needs assessment. These names are summarized in a document that is attached to the minutes.

The groups were also asked to consider the following questions: what do the group members need from the needs assessment, and what does the state need from the needs assessment? Feedback from each group is summarized below, by question.

Group Members Need from the Planning Process

Housing

- Identify the needs, the areas, the dollars, and the barriers (let resources actually meet need, have a proportional response so that resources are not developed that then stand empty)
- Comprehensive plan or a framework to accomplish the goals; direction
- Fair housing laws—ensure that consumers know their rights and that providers know their obligations (people need education and training)
- Identify demographics and then break down information by county; do not want all the information to relate just to the state as a whole; do want county-level and regional data

Services

- Need to know about gaps in service (for women, for youth, etc.)
- How many types of responses are needed, what types (independent, transitional, with supports)
- What types of support services are needed in every type of program
- PWAs need to know what programs are available, NOW
- Better communication
- Directories of services in each area
- Education for providers
- How to get a handle on the situation/need
- Ways to make PWAs feels safe—people must feel safe, if they are going to access services and housing

HIV

- A stable, secure housing plan for people with HIV, leading to compliance and access to treatment for the long haul

State Needs from the Planning Process

Housing

The group felt that what is needed by the state is the same as for the community of housing providers summarized previously. As they considered the questions, the response just seemed to be the same. One participant commented, "We are not an island, what happens at the state impacts the communities, and what happens in the communities happens to the state."

Services

- What are the trends in HIV infection that are meaningful (more women, more kids, etc.)? State needs to develop a vehicle for communicating this information. We need to get people focused on this issue and get some energy out in front of the need.

- Communication across the state. How to get funds to address this issue? Make sure that people are aware.
- Honest fiscal evaluation of what we do versus what we do not do. And if we do not do it, what is the societal cost? It will capture the attention of the midwestern psyche and values.
- Shift in attitude from incarceration to treatment and prevention. People are sick, this is a disease and people need treatment, and so let us get about the business of doing this.
- State should provide safe access to services for PWAs.

HIV

Similar to the housing group, the HIV group felt that the response to the previous question would apply here also. If this all works well, the state will see a decrease in HIV infections, resulting in increased resources (funding) and productivity. The group added: "Part of our hope is to start to develop linkages between providers working in different arenas; hopefully these linkages grow."

Steering Committee

Randall Russell provided more information about the role of the Steering Committee and upcoming meetings. He emphasized that in the future, the facilitators will do less talking and presenting, and opportunities will be provided for committee members to think and talk together and to network. The Steering Committee members and other local stakeholders are the experts. The continued participation and commitment of the committee is essential. Steering Committee members were asked to stay engaged in the process throughout.

Possible dates for the next Steering Committee meeting were discussed. Because of a potential conflict, the date was not finalized. AIDS Housing of Washington and Nebraska Health and Human Services will confer and inform committee members of the date as soon as possible.

Liz Wall and Randall Russell explained that once the HUD Super NOFA is issued, which is expected at any time, they will not be able to participate in discussions about the Housing Opportunities for Persons with AIDS (HOPWA) proposal that will be submitted by community stakeholders. As a HUD-funded technical assistance provider, AIDS Housing of Washington cannot assist individual applicants with grant development. Liz and Randall reminded participants that the needs assessment would look at AIDS housing issues and needs very broadly.

Meeting Close

Randall closed the meeting by asking some participants to comment on how the meeting was for them. Response included: fantastic, painless, educational, enlightening, eclectic, and exciting.

April 21, 2003

Committee Members Present:

Name	Affiliation
Diane K. Adams	*Lexington Housing Authority, Lexington*
Kim Anderson	*Freedom House Management/South Central Behavioral Services*
Pat Compton	*NE Dept. of Economic Development/Special Needs, Kearney*
Joseph Conrad	*NAP, Omaha*
Becky Diercks	*Community Action Partnership of Mid Nebraska, Kearney*
Demond Flowers	*Family Housing Advisory Services, Omaha*
Steve French	*NAP Volunteer*
Dana Grisham	*Community Alliance, Omaha*
Dennis Hoffman	*Centerpointe, Lincoln*
Judy Hughes-Anderson	*NHHS, Lincoln*
Sandy Klocke	*NHHS, Lincoln*
Janet Oberhauser	*CPG Northern Region*
Karen Parde	*HHS-CSGB*
Paulette Pool	*Hastings Housing Authority, Hastings*
Erin Porterfield	*NAP, Omaha*
Dean Settle	*Community Mental Health Center of Lancaster County, Lincoln*
T.J. Seward	*NAP, Omaha*
Tim Sullivan	*NAP, Omaha*
David Traster	*People's City Mission, Lincoln*
Cindy White	*NRRC*
Russell Wren	*NHHS, Lincoln*

Liz Wall and Randall Russell, *AIDS Housing of Washington*

Welcome and Introductions

Liz Wall welcomed participants to the second meeting of the HIV/AIDS housing needs assessment Steering Committee and reinforced the role of the steering committee in the process of developing the plan. She reviewed the minutes from the past steering committee meeting and the agenda for today's meeting. Participants were asked to introduce themselves. Participants attending their first Steering Committee meeting were given a brief overview of progress to date.

Review of Background Sections

Liz Wall led meeting participants through a review of the background sections of the plans. Information was clarified as necessary.

- **Population Demographics:** No comments.
- **HIV/AIDS in Nebraska:** Participants asked some questions about the HIV/AIDS data included in this section. How was the data determined and are there people who are left out of the counts? The data was provided by the State of Nebraska and does not include those people who have not been tested for HIV or those who have been tested anonymously. The table that lists numbers by region (Central, West Central, etc.) is confusing. The name of each county should be listed in a footnote. Perhaps a map could be included. Some participants were surprised that the cost of HAART therapy averaged $10,000 to $15,000 per person per year.

- **Housing and Homelessness:** It was requested that data about the resources available through housing authorities be added as well as more information about the Continuum of Care. Nebraska Department of Economic Development sets aside about $576,000 for special needs housing. Housing developers can access the funding; however, there were $2 million in application requests for special needs housing dollars this year. It was requested that some information about the USDA programs that operate in Nebraska be included. They are important sources of funding.
- **Dedicated Resources:** Title II doesn't fund health care outside of ADAP. The presentation of data needs to be reviewed. "Continuum of care" language might be confusing as it can be used to reference a number of different populations.
- **Survey findings:** No comments.

Report on Consumers and Key Stakeholders

Randall Russell reviewed the initial findings from the key stakeholder interviews and consumer focus groups. Thirty-eight consumers in seven cities (Lincoln, Kearney, Omaha, Norfolk, North Platte, Fremont, and Scottsbluff) and sixty-nine providers/stakeholders from throughout the state (about 40 percent from areas outside of Lincoln and Omaha) have been contacted and interviewed. Randy presented an overview of the concerns and challenges that were identified by consumers and/or stakeholders:

Environment

- HIV is an "invisible disease." Many believe there is a high level of ignorance about the disease. Participants shared experiences of violence and shunning and discussed how fear keeps people from disclosing their status and accessing care.
- Many consumers are petrified. Most have experienced direct discrimination.
- Major gaps in the availability of services generally were identified in rural areas as compared to Omaha, Lincoln, and other larger communities.
- Providers who participated in interviews predicted challenges for community acceptance of housing programs for HIV-positive residents.

Consumer Housing Histories

- Since becoming HIV-positive, most have been faced with housing challenges including financial burdens, discrimination by landlords or neighbors, lack of knowledge of what resources are available, and a lack of willingness to access services for fear of having to disclose status.
- Current housing situations are not adequate. Many have insufficient financial resources to maintain their quality of life. Some reported going without medications, many are making poor food choices, and many faced homelessness on a regular basis.

HIV Stigma

- Many consumers shared stories of violence and intimidation: bullets in windshield, direct physical attacks, etc.
- Many community members have the perception that if someone is gay they are HIV-positive and that if someone is HIV-positive they are gay. There is a high fear of both.

Consumer Housing Choices

- Preference is for single-family units integrated in a residential environment.
- No HIV-identified units should be developed.

- Mixed-use facilities for special needs might work in some places.
- Rental assistance is a major help.
- Need increased translation between housing world and medically-based HIV world.
- In order to respond well to consumer needs, it is critical that there be local control of the housing interventions implemented in both rural and urban areas.

Provider Optimism

- Everyone wants to help.
- Most providers indicated that they did not understand what the specific needs were but were very open to collaborations that would increase housing choices.
- Most providers were unaware of their own community's offerings.
- Many providers were unaware of how services (of any kind, not just HIV) connect to housing.
- There was a lack of understanding of funding streams for housing.

Owner/Developer & Provider & Operator

- There are waiting lists in most places but some new developments are under way that would be appropriate for people living with HIV/AIDS.
- There is a great shortage of homeless services (shelters and transitional). Some identified a need for increased coordination.
- A number of sophisticated housing developers participated in stakeholder meetings, but they are not necessarily easily linked with local providers.
- Many expressed a clear willingness to dedicate units for people with special needs, including HIV/AIDS, if known service providers handled case management.

Meeting participants were interested in knowing how the stigma issue compares between Nebraska and other places. They also were surprised to discover that services are disconnected in these communities. They wanted to know what the disconnects were and whether or not the Continuum of Care met in these communities. One participant expressed the opinion that "the smaller towns have heart" and wanted to explore how to build connections in those communities. Issues related to fair housing were also raised.

Brainstorming of Issues Critical to Housing People Living with HIV/AIDS

Liz Wall and Randall Russell led the group through a process of brainstorming the issues critical to serving people living with HIV/AIDS. The group identified the following:

- There is a disconnect between resource collector, developer, and connecter.
- "I am appalled and embarrassed," said one participant. Education is needed.
- Stigma in general. People deal with it daily. Need responses across issues to decrease stigma. Need "stigma busters" that make sense. One mental health provider said that "Stigma is a thousand-pound gorilla that most of us carry around, even providers."
- One participant identified commonalities—like stigma, no choice, need for support systems, and availability of units—that impact many different people. "You have a passion to do everything you can to help and you feel isolated, but there are commonalities."
- Stigma goes further than just HIV/gay/etc. One participant noted that women have more options for resources if they do not disclose their status (women do not get questioned as men do; not as many assumptions are made).
- Focus on strengths and how to draw attention to issues/possibilities/connections.

- Need resource guide to various meetings/planning processes, etc.
- It is critical to educate people living with HIV/AIDS.
  - There is a lack of knowledge about programs and resources.
  - Educate consumers about program criteria, eligibility limitations, what one can realistically expect, impact on other services entitlements, entitlements/benefits counseling (people worry about returning to work)
  - Also need continuing education once housed to assist people to maintain stability. Rules change, a person's level of cognitive functioning changes, etc.
- There is a need for linkage to faith-based providers and communities

Next Steps

The final two meetings of the Steering Committee were scheduled for June 12th and July 8th. Both meetings will be held in Grand Island. The June meeting will focus on the identification of critical issues and the July meeting will focus on the development of recommendations.

June 12, 2003

Committee Members Present:

Name	Affiliation
Diane K. Adams	*Lexington Housing Authority, Lexington*
Kim Anderson	*South Central Behavioral Services*
Nancy Bentley	*Scotts Bluff County Housing Authority*
Amanda Buscher	*NAP, Omaha*
Pat Compton	*NE Dept. of Economic Development/Special Needs, Kearney*
Joseph Conrad	*NAP, Omaha*
Becky Diercks	*Community Action Partnership of Mid Nebraska, Kearney*
Demond Flowers	*Family Housing Advisory Services, Omaha*
Steve French	*NAP Volunteer*
Steve Gable	*NRRC – NAPWA – PACT – PWA – NAP Volunteer*
Dana Grisham	*Community Alliance, Omaha*
Judy Hughes-Anderson	*NHHS, Lincoln*
Sandy Klocke	*NHHS, Lincoln*
William R. Mann	*NAP Volunteer*
Betty Medinger	*HHS, Homeless Assistance Program, Community Services Block Grant*
Janet Oberhauser	*CPG Northern Region*
Paulette Pool	*Hastings Housing Authority, Hastings*
Dean Settle	*Community Mental Health Center of Lancaster County, Lincoln*
T.J. Seward	*NAP, Omaha*
Ron Snell	*Lincoln County Community Services*
Tim Sullivan	*NAP, Omaha*
Elaine Wiseman	*Kearney Housing Agency*
Russell Wren	*NHHS, Lincoln*

Randall Russell, *AIDS Housing of Washington*

Welcome and Introductions

Randall Russell (facilitator) opened the meeting and welcomed the participants to the Critical Issues meeting of the Nebraska HIV/AIDS Housing Needs Assessment Steering Committee. Randy informed the participants that Liz Wall was on leave and sent her regards and would be at the July meeting, the final meeting of the Steering Committee. Attendees introduced themselves and the facilitator reviewed the process for the meeting. Two separate topics were identified as the focus of the meeting: a) review of the consumer focus group and key stakeholder chapters sent to the steering committee in advance of the meeting, and b) identification of critical issues.

Review of Findings Sections

A number of sections of the plan were mailed to Steering Committee members in advance of the meeting for their review. The chapters were reviewed and comments are summarized below.

Consumer Focus Groups Chapter

The following general comments were made about this chapter:

- Housing authority representatives were concerned to hear that payments did not go out on time.

- Providers in general were concerned about the fear of the consumer to come to the office.
- There is a disconnect between the provider and the consumer. The perceptions of the consumer are that his or her status will be revealed, which surprised the providers because no one's disability is ever released.

Changes on page 1:

- There was a concern expressed that only 38 consumers attended the focus groups. It would be helpful to state in the beginning how the recruitment was done and some perceptions based on results as to why some of the focus groups had so few people attend. The fact that so few came also sends a message and that needs to be stated somehow. Perhaps we need to restate here that more than 200 people living with HIV/AIDS who completed housing surveys are also represented in the process.
- Let's add that the belief of the Steering Committee is that even if the "n" were much larger, the conclusions and recommendations would not be altered.
- Some people will not enroll in care because of their fear of discrimination. Providers noted that they will appropriately keep sensitive information in confidence, but that a) this is not known by consumers, and b) this probably would not change the consumer's reluctance to approach a provider for assistance.
- One participant wondered why there were only two people who came to the consumer focus group in Lincoln, and, since Lincoln is the second highest incidence area, whether that level of participation is acceptable for this process. Randall noted that those who attended represented a number of people by talking about themselves and their friends who were positive. One issue that impacted participation was the turnover in the local NAP office.
- One consumer noted: "I lived in Lincoln for three years, and I was HIV-positive for three years, and I saw a private doctor, but I never knew about or heard about anything in Lincoln. I knew NAP was in Omaha, but didn't know they were also in Lincoln."

Changes on page 2:

- Add somewhere that more and more people from the general population are moving to Lincoln and Omaha from other parts of the state, which means that some of the pervasive conservative thinking of more rural areas impacts the cities of Lincoln and Omaha. Adding a note to this effect in the population section of the plan might be helpful. One Lincoln provider thought that about half of the people in Lincoln have moved from somewhere else.

Changes on page 3:

- One participant stated: "These comments make me think about how the perception of the consumer is that people will need to know their disability is HIV disease and that keeps them away."
- One participant stated: "We need to emphasize the low-income piece, that it isn't just HIV, it's poverty. Is there a way to stress that?"

No changes were identified on pages 4 and 5.

Changes in Consumer Focus Group Summaries

The group agreed that place names should not be included in the summaries. For example, the notes now name the specific state or region that someone moved from, but the group agreed it would be better to simply leave these references out. These references will be deleted.

Review of Key Stakeholder Interview Chapter

Changes on page 1:

- One participant wondered if it is possible to say that housing authority resources vary. Some would prefer to say that resources vary because some have vacancy and some do not.
- It might be useful to add another theme about poverty—the lack of disposable income for transportation, etc.
- One participant noted that the majority of Nebraska's general assistance programs do not provide deposit money to assist someone to get into a unit.

Changes on page 2:

- The pull-out comment about "Housing is a blip" didn't make sense to meeting participants. It should be placed into context or removed.
- Although the stakeholders didn't say it this way, the group asked for an editor's note to be added to indicate that rural and urban areas lack affordable housing stock.
- Another editor's note would be useful in the discussion of the taxation of rental property. The Unicameral Bill 292 has waived the need for tax-credit projects to pay a property tax. So while it is true that all property taxes were required, this new bill waives those taxes for tax-credit projects.

Changes on page 3:

- First paragraph. The use of the word "siting" didn't make sense to the group. "Location" or "locating a project" would be a better way to reference the work.

Changes on page 4:

- The group would like an editor's note that says that whatever information is in the file about tenants is confidential by federal requirement and by law—sometimes, information is placed in a sealed envelope in the file. The group understands that it is perception and not necessarily reality, and they would like some context provided.
- The Fair Housing group has been receiving more complaints from persons with HIV. The group is starting to send out testers in urban and rural areas.
- Comment: Homeless shelters are asked to fill out forms about how many people have HIV, are mentally ill, are vets, etc., but the homeless shelter guest is not asked any of those questions. How do we work around the delicate balance of confidentiality? The policy of not asking is the appropriate policy; but providers are sometimes, depending on funding streams, expected to collect data. If a person discloses they have HIV, the other guests can make it difficult for that person to want to stay there because they are shunned.
- Somehow we need to capture that while HIV specialty-care providers from Omaha (including satellite clinics) and Scottsbluff provide HIV-specific care along with some private doctors, the lack of primary health care creates a problem. The point keeps getting made that consumers have to travel a long way and there are stories from case managers about consumers driving five hours when they are sick to go to "their" doctor. The gap in trust of medical care for primary and HIV-specific HIV care needs to be addressed.
- The city of Oneill is spelled wrong (currently Oneal). People don't travel from Norfolk to Oneill, people travel from Oneill to Norfolk.

Changes on pages 5 and 6

- It is not clear that there is an HIV problem among the immigrant populations (Hispanic, Sudanese). Participants wondered if we could add something about national trends to document the extent of the problem.

- Perhaps include an editor's note that says that we have not accurately documented the correlation of HIV and immigrant populations. Perhaps it should be in the background section, but it should be included somewhere.
- Perhaps include an editor's note that says that there are translators available for free through the Literacy Councils that are located across the state. We may want to make that point clear for edification of the reader of the plan.

Initial Identification of Critical Issues

Randall Russell led a process whereby Steering Committee members identified critical issues impacting the provision of housing and related services to people living with HIV/AIDS in Nebraska. The process included individual and small group work followed by a process which included all meeting participants.

First, participants were asked to write what they perceived to be the most critical issue on an index card and to hold onto that card. Second, the group was randomly divided into thirds and each group was requested to come up with 5 to 12 critical issues. This process allowed for individual and group input from the committee. The groups worked together for 45 minutes and each group included service providers, housing providers, and consumers.

The small group discussion results were summarized at the front of the room and 28 issues were identified. In some cases, the small groups identified similar issues. Those ideas were merged together to arrive at the listing of unique critical issues. To set the stage for the development of recommendations, the full group was asked to rank, on a scale from one to ten, the issues they felt were most important. The draft issues are presented below in the order in which they were ranked.

1. Lack of affordable, safe, decent, appropriate housing choices for the full continuum of housing options
2. Lack of money for clients in poverty and providers for funding of needed programs
3. Need to increase collaboration between housing providers and AIDS service organization case workers
4. Lack of confidentiality education to bridge gap between perception and practice
5. Need to increase awareness of housing options among consumers and service providers
6. Lack of linkage between housing and support services for HIV-positive persons who are in need of housing or who are housed
7. Stigma of HIV disease for persons living with the virus
8. Lack of transportation
9. Empowering clients to partner with case management
10. Lack of community education and tolerance/acceptance of persons living with HIV
11. Lack of services (medical, case management, dental, etc.)
12. Provider fears block the ability of those living with HIV to access jobs, housing, services, etc.
13. The impact of high medical expenses on consumers and how that may increase the poor credit ratings blocking housing options
14. Cultural challenges of persons who are Hispanic, Sudanese, poor, urban, rural
15. Lack of persons living with HIV accessing needed services due to the fear of providers
16. Increase the awareness of employment opportunities through the new Nebraska "Ticket to Work" program allowing persons on disability to earn more
17. Surviving HIV/AIDS can be a major long-term issue: more people in long-term care and changing environments and needs for support services
18. Lack of diversity among providers for persons with HIV

Each member of the group was asked to revisit the initial critical issue they noted on the index card and to note on the opposite side of the card if the group process had changed their opinion. The table below presents the results of this exercise. If the last column indicates a "Yes" at least one of those who originally listed one

of the other critical issues changed to this issue. If the last column indicates a no then the persons listing this issue did not change their critical issue after the group process.

Issue area	Number of persons making similar comments	At least one person indicated a change of opinion from before the group process to after the group process.
Fear, being found out as HIV-positive and then being discriminated against, assurance from providers of confidentiality, stigma	7	Yes
Lack of accessible, affordable, safe, appropriate housing choices across the housing continuum for persons with HIV/AIDS with low incomes	7	Yes
Lack of provider awareness about consumers' fear of accessing services	6	No
Lack of education for HIV-positive persons about how confidentiality is maintained by providers	5	Yes
Lack of knowledge among consumers about what resources are available to them	5	Yes
Lack of knowledge about HIV disease among providers and general population	4	Yes
Poverty	3	No
Disconnect between housing providers and persons living with HIV	2	No
Lack of provider funding to address the need for increased housing stock	1	No
Lack of support services linked to housing as needed while assuring confidentiality	1	No
Lack of the availability of case management services to link people living with HIV disease with appropriate housing options	1	No

Conclusion and Announcements

It was announced that Joe Conrad and Cindy White would be representing Nebraska as presenters at the upcoming joint conference between the National Alliance to End Homelessness, the Corporation for Supportive Housing, and AIDS Housing of Washington to be held in Washington, DC, July 16–19, 2003. They will present on consumer involvement as it relates to advocacy and housing. Persons were invited to join the conference.

The state announced its HOPWA Competitive application submission. The Lincoln newspaper carried a front-page story about this year's grant submission, including restated support from state leaders for the submission of the application to HUD this year.

The facilitator thanked the participants for their time and investment in the process and encouraged everyone to attend the July 8th meeting where final recommendations would be made.

July 8, 2003

Committee Members Present:

Name	Affiliation
Diane K. Adams	*Lexington Housing Authority, Lexington*
Nancy Bentley	*Scotts Bluff County Housing Authority*
Daniel Cobos	*UNMC, Omaha*
Pat Compton	*NE Dept. of Economic Development/Special Needs, Kearney*
Joseph Conrad	*NAP, Omaha*
Becky Diercks	*Community Action Partnership of Mid Nebraska, Kearney*
Demond Flowers	*Family Housing Advisory Services, Omaha*
Steve French	*NAP Volunteer*
Steve Gable	*NRRC – NAPWA – PACT – PWA – NAP Volunteer*
Theresa Gauff	*Salvation Army*
Dana Grisham	*Community Alliance, Omaha*
Barb Hansen	*Nebraska AIDS Project, Kearney*
Judy Hughes-Anderson	*NHHS, Lincoln*
Sandy Klocke	*NHHS, Lincoln*
Connie Longie	*Panhandle Mental Health Center*
Paulette Pool	*Hastings Housing Authority, Hastings*
Erin Porterfield	*Nebraska AIDS Project, Omaha*
T.J. Seward	*NAP, Omaha*
Ron Snell	*Lincoln County Community Services*
Tim Sullivan	*NAP, Omaha*
Cindy White	*NRRC*
Elaine Wiseman	*Kearney Housing Agency*

Elizabeth Wall and Randall Russell, *AIDS Housing of Washington*

Welcome and Introductions

Randall Russell welcomed Steering Committee members and reviewed the day's agenda. Meeting participants introduced themselves.

The Nebraska Department of Health and Human Services submitted an application for funding through the HOPWA Competitive program. Sandy Klocke provided the group with an overview of the grant proposal. Some of the highlights of the grant include:

- $1.3 million over 3 years
- Tenant-based rental assistance
- Short-term rent, mortgage, and utility assistance
- One goal is to support people to access permanent housing
- Housing information for HIV-positive people and their families
- Case management to address housing needs and for those with multiple service needs
- Information for providers regarding resources
- Consumer education
- Limited mental health and substance use services
- Transportation assistance
- Funding a housing specialist position to link to/develop housing resources

Review and Affirm Critical Issues

Participants reviewed the critical issues individually and in categories. Some changes in language to specific critical issues were discussed and agreed to.

One participant indicated that, for him, the unique issue that separates the needs of people living with HIV/AIDS from the needs of other low-income people in the state is stigma and discrimination. He suggested that the critical issues related to stigma and discrimination be presented first and then affordable housing issues. The group agreed to this change.

One participant asked that the introduction to the section summarizing critical issues in regard to support services include a reference to the fact that the cost of services a person is otherwise eligible for might make the resource unavailable (for example, the co-pay required for prescriptions might be unaffordable to a person, even if they receive Medicaid). This addition will be made.

One participant noted that the critical issues did not address stigma and discrimination related to sexual orientation, although consumers and providers raised the issue during the needs assessment. The group agreed to add a bullet point on this issue.

Development of Recommendations

The Steering Committee considered each critical issue area and developed recommendations and strategies to address the critical issues. Although the group considered the critical issues by category, some of the recommendations and strategies that emerged from conversation about one critical issue area more appropriately addressed another issue area. The following summary reflects the conversation of the group; the recommendations will be reorganized as necessary for inclusion in the plan.

Stigma and Discrimination

Liz provided a summary of the critical issues related to stigma and discrimination. The group brainstormed the following recommendations and strategies to address the identified critical issues.

1. In order to dispel myths, educate the following groups about HIV/AIDS and the impact of the disease in Nebraska:
   - Housing and service providers
   - General public
   - Employers/training programs
   - People living with HIV/AIDS (some carry fears that are not accurate)
   - Politicians/policy makers
   - Real estate affinity group, landlords, property management
   - Medical providers
   - Populations at risk

   Suggested strategies:
   - Build on existing relationships to provide education; for example, engage a friendly landlord to assist with education efforts for those in the housing industry.
   - Share personal stories in order to humanize HIV/AIDS and the people living with the disease; utilize PSAs, websites, clearly articulate that a range of people are living with the disease (race, age, class, sexual orientation, etc.).

- Increase political leaders' public support of the issue
- Support and enhance prevention efforts already under way

One participant remarked: "Confidentiality is the enemy of education; the more you try to hide it, the harder it is to educate."

2. Increase consumer knowledge in order to facilitate access to housing and housing stability. Educate consumers about the following topics:
   - Fair Housing laws, renters' rights and responsibilities
   - Life skills, money management/budgeting, renter readiness
   - Awareness of what is required to access public housing authorities
   - Empower consumers so that they have the knowledge they need and increased willingness to exercise their housing rights

Affordable Housing Options

Liz summarized the critical issues related to the availability of affordable housing. The group brainstormed the following recommendations and strategies to address the identified critical issues.

- Educate consumers about available housing options and opportunities.
- Assist consumers to address and eliminate barriers to housing stability. Address topics such as poor credit, relapse prevention, tenant rights and responsibilities, fair housing laws, and housing search strategies.
- Advocate to governmental entities for political and financial support (funding) for affordable housing development at the federal, state, and local levels.
- Increase affordable housing units available to people living with HIV/AIDS.
- Develop, enhance, and continue relationships between service providers (AIDS service organizations, mental health and substance use treatment providers, property owners and landlords, etc.).
- Increase opportunities for emergency housing solutions and access for people living with HIV/AIDS. Educate consumers about existing programs. Increase linkages. Develop additional resources as needed.
- Ensure the needs of people living with HIV/AIDS are represented in housing and services planning processes.
- Develop a listing of HIV/AIDS services available, including eligibility criteria and contact information.
- Apply for all additional resources that support affordable housing strategies identified in the plan.

Access to Support Services

Liz summarized the critical issues related to access to support services. The group brainstormed the following recommendations and strategies to address the identified critical issues.

- Increase support services for people with mental health and substance use issues.
- Provide relapse-prevention support for people with substance use issues.
- Increase access to services.
- Provide education about available resources.
- Ensure and increase access to appropriate services for people who are monolingual through translated materials and access to translators. Increase volunteerism and linkages to agencies already working with these populations.
- Transportation resources need to be increased so that people can access support services. If new housing is developed, access to support services must be considered.

- Increase availability of support services for people in suburban and rural areas.

Financial Issues

Liz summarized the critical issues related to access to support services. The group brainstormed the following recommendations and strategies to address the identified critical issues.

- Enhance economic opportunities for persons living with HIV/AIDS through linkages with Vocational Rehabilitation, Ticket to Work, Workforce Development, and the VA.
- Increase case management resources.
- Explore opportunities to develop a comprehensive peer-to-peer mentoring program to access the programs available to HIV disease.

Review of Draft Recommendations

Liz explained that the recommendations would be fully drafted and organized in a manner that made the recommendations easy to review and understand. The draft recommendations will be mailed to Steering Committee members next week for review.

Next Steps and Closure

Randy provided an overview of next steps, including the timeline for review of the draft recommendations and the draft plan. The draft plan will be completed in late July and will be forwarded to Steering Committee members in its entirety for final review and comment.

Sandy Klocke told the group that their participation during the planning process had been invaluable and requested that the group come together at least one more time to assist with the development of an implementation plan. The group agreed to another meeting in the fall.

In closing, Randy asked each participant to share one word that described his or her experience of the planning process. Some of the responses included:

- So many words
- Interesting
- Inspiring
- Amazing
- Eye-opening
- Educational
- Beginning
- Housing authorities "get" people with disabilities

People expressed their appreciation to the facilitators for a planning process that was respectful of their time and participation, including sending materials in advance of the meeting and adapting those materials as needed so that all participants could come to the meeting prepared.

One meeting participant who is living with HIV/AIDS told the group that their participation in the process was heartening to him. He expressed his thanks to the group for their commitment and noted, "We do have friends who are actually strangers."

September 25, 2003

Committee Members Present:

Name	Affiliation
Jean Chicoine	*NHHS, Homeless Assistance Program*
Pat Compton	*NE Dept. of Economic Development/Special Needs, Kearney*
Joseph Conrad	*NAP, Omaha*
Becky Diercks	*Community Action Partnership of Mid Nebraska, Kearney*
Steve French	*NAP Volunteer*
Steve Gable	*NRRC – NAPWA – PACT – PWA – NAP Volunteer*
Dana Grisham	*Community Alliance, Omaha*
Judy Hughes-Anderson	*NHHS, Lincoln*
Sandy Klocke	*NHHS, Lincoln*
Erin Porterfield	*Nebraska AIDS Project, Omaha*
Galen Sears	*NRRC*
Dean Settle	*Community Mental Health of Lancaster County*
Elaine Wiseman	*Kearney Housing Agency*

Elizabeth Wall, *AIDS Housing of Washington*

Welcome and Introductions

Liz welcomed Steering Committee members and informed them that Randy Russell would not be attending the meeting due to illness. Liz reviewed the day's agenda. Meeting participants introduced themselves.

Final Review of Plan Contents

Participants were given a final opportunity to comment on the draft plan. A few minor comments were made about the wording of two sections in the Key Stakeholders Findings section, including:

- In the transportation summary, could we add the word "appropriate" at the start of the second sentence so that we say "appropriate affordable housing"? Some affordable housing is found along bus lines, but it isn't necessarily the most appropriate housing.
- Two paragraphs later, under the funding support services issue, please note that there is a shelter in Omaha that will serve people even if they are not sober. The text will be changed.

Meeting participants reviewed the lists of process participants and made corrections as needed.

Development of Action Steps

The Steering Committee reviewed recommendations and discussed both overarching principles that should guide implementation efforts and specific action steps to take in implementing certain recommendations.

Overarching principles include:

- It would be helpful to have ongoing communication on HIV/AIDS housing issues—quarterly at a minimum. In January 2004, Nebraska Department of Health and Human Services will provide an update on progress on plan implementation and an update on the HOPWA Competitive application that was submitted in June.

- Annually assess progress on the implementation of the plan's recommendations and develop measurable goals. Evaluate annually. Develop additional action steps.
- As needed convene time-limited workgroups to address specific recommendations.
- To the extent possible, coordinate efforts to avoid duplication of the work of other community groups and committees.
- Implementation of these strategies relies on the participation and leadership/guidance of a broad range of stakeholders. Initially, responsibility will rest with Nebraska Department of Health and Human Services and the Nebraska AIDS Project as the two agencies that have heretofore taken the lead on AIDS housing issues in Nebraska. The goal is that leadership will continue to emerge from a broader group of community stakeholders in order to draw on and include existing expertise and resources.
- Committee members noted that the participation of people living with HIV/AIDS in advocacy and planning efforts is essential and that advocacy efforts are most effective when consumer advocates and providers work hand-in-hand to address issues of concern. However, a need for education and training for consumer advocates was identified. The mental health system works to provide necessary training and education to consumers, and advocacy efforts effectively include consumers. It was also noted that consumers' interests and skills are varied and that efforts should be made to "make room for everybody" who wants to participate. The Nebraska Red Ribbon Committee and Nebraska AIDS Project will work together to identify resources to provide initial and on-going training to people living with HIV/AIDS on effective advocacy strategies. The population of people living with HIV/AIDS in Nebraska is diverse, and people have a range of interests and skills related to community advocacy. It is a value of the Steering Committee that mechanisms be developed to ensure that all people living with HIV/AIDS who are interested in participating in advocacy have a forum through which to do so.

Affordable housing and homeless services planning: The plan includes a series of recommendations that address affordable housing issues, including one that seeks to increase affordable housing units accessible to people living with HIV/AIDS through partnership, planning, increased funding, and advocacy. The Steering Committee focused on the planning aspect of the recommendation, which identified the need for HIV/AIDS providers and advocates to participate in housing and service planning processes.

When discussing the implementation of this recommendation, committee members raised a number of issues including the importance of collaboration and the participation of people living with HIV/AIDS in advocacy efforts, and identified a number of community planning efforts related to ending homelessness and disability issues.

The Nebraska Commission on Housing and Homelessness is a statewide advisory committee that provides input to the governor and the Nebraska Department of Economic Development on a range of policy and program issues related to affordable housing and homelessness. Currently, representatives from the Nebraska AIDS Project and the Nebraska Department of Health and Human Services sit on the Continuum of Care Committee, a sub-committee of the Commission. The Governor appoints the Commission members, while sub-committees can include at-large members. It was recommended that a member of the HIV/AIDS community, preferably a person living with HIV/AIDS, seek a Governor's appointment to the Commission. Jean Chicoine volunteered to find out more information about how appointments are made and share this information with Nebraska AIDS Project.

One important consideration is how relevant information from these meetings gets relayed to the wider HIV/AIDS community. In the coming months, the Continuum of Care committee will focus on how members distribute information to their constituents.

There are seven regional continuum of care planning processes. Currently, Nebraska AIDS Project staff participates in the meetings in Omaha. Feedback and input from these regional planning processes feed into the Consolidated Plan process. Additional local, regional, and statewide forums for planning and information sharing were identified. For example, there are various forums where mental health advocates and service

providers come together. The National Alliance for the Mentally Ill (NAMI) meets regularly in various locations and the Nebraska Mental Health Planning and Evaluation Council (MHPEC) has developed coalitions focused on housing and employment.

Committee members identified the need to determine how information from various forums can be shared in the HIV/AIDS community and how to prioritize the forums where participation of HIV/AIDS advocates would be most beneficial.

Housing stability: One of the recommendations included in the plan aims to increase housing stability and access to housing resources for people living with HIV/AIDS through education and training on a variety of topics. The Nebraska AIDS Project will take the lead on implementing this recommendation, as it currently provides people living with HIV/AIDS a range of support services, such as case management, and refers consumers to appropriate education and training programs. The group identified initial action steps:

- Develop knowledge of providers and available resources of life skills, fair housing, landlord-tenant and other relevant trainings
- Strengthen and develop additional linkages with community-based agencies providing relevant trainings and education programs
- Augment existing resources with relevant information specific to the needs of people living with HIV/AIDS
- Develop education or training programs that target people living with HIV/AIDS when necessary

Next Steps and Closure

The HIV/AIDS housing needs assessment and planning process has officially come to an end. However, Steering Committee members in attendance discussed strategies to keep HIV/AIDS housing issues on the radar. Sandy Klocke, Nebraska Department of Health and Human Services, reiterated the need to develop leadership on HIV/AIDS housing issues among agencies and individuals in the wider community who have expertise on housing issues.

One committee member suggested that meeting participants remain connected through regular contact every few months. The names of all attendees were put into a drawing and each participant pulled out the name of another participant who they would contact in 6 to 8 weeks to check in about relevant issues.

Meeting attendees will receive drafts of the Executive Summary and Action Plan in the next few weeks for final review. AHW will issue the *Nebraska HIV/AIDS Housing Plan* to the Nebraska Department of Health and Human Services in October.

Appendix II: Supporting Data

The following pages present data by county related to population, race and ethnicity, income and poverty, Fair Market Rents, and housing authority resources.

Population

Table A-1:
Population 2002 and 1990 and Percent Change by County

	Total Population 2002	Total Population 1990	Change 1990 to 2002	Percent Change
Nebraska	1,729,180	**1,578,417**	**150,763**	**10%**
Adams County	31,222	29,625	1,597	5%
Antelope County	7,307	7,965	-658	-8%
Arthur County	416	462	-46	-10%
Banner County	765	852	-87	-10%
Blaine County	529	675	-146	-22%
Boone County	6,080	6,667	-587	-9%
Box Butte County	11,868	13,130	-1,262	-10%
Boyd County	2,317	2,835	-518	-18%
Brown County	3,518	3,657	-139	-4%
Buffalo County	42,765	37,447	5,318	14%
Burt County	7,610	7,868	-258	-3%
Butler County	8,854	8,601	253	3%
Cass County	24,839	21,318	3,521	17%
Cedar County	9,264	10,131	-867	-9%
Chase County	3,991	4,381	-390	-9%
Cherry County	6,167	6,307	-140	-2%
Cheyenne County	9,964	9,494	470	5%
Clay County	6,921	7,123	-202	-3%
Colfax County	10,555	9,139	1,416	15%
Cuming County	10,005	10,117	-112	-1%
Custer County	11,501	12,270	-769	-6%
Dakota County	20,339	16,742	3,597	21%
Dawes County	8,996	9,021	-25	0%
Dawson County	24,613	19,940	4,673	23%
Deuel County	2,065	2,237	-172	-8%
Dixon County	6,246	6,143	103	2%

Table A-1, cont.

Population 2002 and 1990 and Percent Change by County

	Total Population 2002	Total Population 1990	Change 1990 to 2002	Percent Change
Dodge County	35,989	34,500	1,489	4%
Douglas County	472,744	416,444	56,300	14%
Dundy County	2,222	2,582	-360	-14%
Fillmore County	6,530	7,103	-573	-8%
Franklin County	3,464	3,938	-474	-12%
Frontier County	2,963	3,101	-138	-4%
Furnas County	5,242	5,553	-311	-6%
Gage County	23,121	22,794	327	1%
Garden County	2,194	2,460	-266	-11%
Garfield County	1,879	2,141	-262	-12%
Gosper County	2,057	1,928	129	7%
Grant County	706	769	-63	-8%
Greeley County	2,653	3,006	-353	-12%
Hall County	53,613	48,925	4,688	10%
Hamilton County	9,371	8,862	509	6%
Harlan County	3,635	3,810	-175	-5%
Hayes County	1,109	1,222	-113	-9%
Hitchcock County	3,023	3,750	-727	-19%
Holt County	11,191	12,599	-1,408	-11%
Hooker County	745	793	-48	-6%
Howard County	6,479	6,057	422	7%
Jefferson County	8,250	8,759	-509	-6%
Johnson County	4,449	4,673	-224	-5%
Kearney County	6,853	6,629	224	3%
Keith County	8,729	8,584	145	2%
Keya Paha County	962	1,029	-67	-7%
Kimball County	3,957	4,108	-151	-4%
Knox County	9,082	9,564	-482	-5%
Lancaster County	257,513	213,641	43,872	21%
Lincoln County	34,390	32,508	1,882	6%
Logan County	743	878	-135	-15%
Loup County	739	683	56	8%
McPherson County	546	546	0	0%
Madison County	36,035	32,655	3,380	10%
Merrick County	8,033	8,062	-29	0%

Table A-1, cont.
Population 2002 and 1990 and Percent Change by County

	Total Population 2002	Total Population 1990	Change 1990 to 2002	Percent Change
Morrill County	5,291	5,423	-132	-2%
Nance County	3,911	4,275	-364	-9%
Nemaha County	7,306	7,980	-674	-8%
Nuckolls County	4,843	5,786	-943	-16%
Otoe County	15,458	14,252	1,206	8%
Pawnee County	3,030	3,317	-287	-9%
Perkins County	3,065	3,367	-302	-9%
Phelps County	9,593	9,715	-122	-1%
Pierce County	7,846	7,827	19	0%
Platte County	31,215	29,820	1,395	5%
Polk County	5,518	5,655	-137	-2%
Red Willow County	11,372	11,705	-333	-3%
Richardson County	9,094	9,937	-843	-8%
Rock County	1,714	2,019	-305	-15%
Saline County	14,121	12,715	1,406	11%
Sarpy County	129,319	102,583	26,736	26%
Saunders County	19,894	18,285	1,609	9%
Scotts Bluff County	36,764	36,025	739	2%
Seward County	16,665	15,450	1,215	8%
Sheridan County	6,064	6,750	-686	-10%
Sherman County	3,173	3,718	-545	-15%
Sioux County	1,426	1,549	-123	-8%
Stanton County	6,536	6,244	292	5%
Thayer County	5,692	6,635	-943	-14%
Thomas County	699	851	-152	-18%
Thurston County	7,199	6,936	263	4%
Valley County	4,542	5,169	-627	-12%
Washington County	19,211	16,607	2,604	16%
Wayne County	9,497	9,364	133	1%
Webster County	3,973	4,279	-306	-7%
Wheeler County	876	948	-72	-8%
York County	14,345	14,428	-83	-1%

Sources: U.S. Census Bureau, Population Division, Table CO-EST2002-01-31: Nebraska County Population Estimates: April 1, 2000 to July 1, 2002, Release Date: April 17, 2003. Available online: eire.census.gov/popest/data/counties/tables/CO-EST2002/CO-EST2002-01-31.php (Accessed August 4, 2003). U.S. Census Bureau, (CO-99-2) County Population Estimates for July 1, 1999 and Population Change for April 1, 1990 to July 1, 1999 (includes revised April 1, 1990 population estimates base), March 9, 2000. Available online: eire.census.gov/popest/archives/county/co_99_2.php (Accessed: January 28, 2003). AIDS Housing of Washington calculated percent change.

Race and Ethnicity

Table A-2:
Race and Ethnicity of Population by County of Nebraska, 2000

	White	African American/ Black	American Indian and Alaska Native	Asian	Native Hawaiian and Other Pacific Islander	Other race	Multiracial	Hispanic/ Latino
Nebraska	**90%**	**4%**	**1%**	**1%**	**<1%**	**3%**	**1%**	**6%**
Adams County	95%	1%	<1%	2%	<1%	2%	1%	5%
Antelope County	99%	<1%	<1%	<1%	—	<1%	<1%	1%
Arthur County	96%	—	<1%	1%	<1%	1%	2%	1%
Banner County	96%	<1%	<1%	<1%	—	3%	1%	6%
Blaine County	99%	—	1%	—	—	—	1%	<1%
Boone County	99%	<1%	<1%	<1%	<1%	<1%	<1%	1%
Box Butte County	91%	<1%	3%	1%	<1%	4%	2%	8%
Boyd County	99%	—	1%	<1%	<1%	—	<1%	<1%
Brown County	99%	<1%	<1%	<1%	<1%	<1%	1%	1%
Buffalo County	95%	1%	<1%	1%	<1%	2%	1%	5%
Burt County	98%	<1%	1%	<1%	<1%	<1%	1%	1%
Butler County	98%	<1%	<1%	<1%	<1%	1%	<1%	2%
Cass County	98%	<1%	<1%	<1%	<1%	<1%	1%	1%
Cedar County	99%	<1%	<1%	<1%	<1%	<1%	<1%	<1%
Chase County	98%	<1%	<1%	<1%	<1%	1%	<1%	3%
Cherry County	94%	<1%	3%	<1%	<1%	<1%	2%	1%
Cheyenne County	96%	<1%	1%	<1%	<1%	1%	1%	4%
Clay County	98%	<1%	<1%	<1%	<1%	1%	<1%	3%
Colfax County	82%	<1%	<1%	<1%	<1%	16%	2%	26%
Cuming County	96%	<1%	<1%	<1%	<1%	3%	1%	5%
Custer County	99%	<1%	<1%	<1%	—	<1%	1%	1%
Dakota County	79%	1%	2%	3%	<1%	13%	3%	23%
Dawes County	93%	1%	3%	<1%	<1%	1%	2%	2%
Dawson County	82%	<1%	1%	1%	<1%	14%	2%	25%
Deuel County	97%	<1%	<1%	<1%	—	1%	1%	3%
Dixon County	95%	<1%	<1%	<1%	—	4%	1%	5%
Dodge County	96%	<1%	<1%	1%	<1%	2%	1%	4%
Douglas County	81%	12%	1%	2%	<1%	3%	2%	7%
Dundy County	97%	<1%	1%	<1%	<1%	1%	1%	3%
Fillmore County	98%	<1%	<1%	<1%	<1%	1%	1%	2%

Table A-2, cont.
Race and Ethnicity of Population by County of Nebraska, 2000

	White	African American/ Black	American Indian and Alaska Native	Asian	Native Hawaiian and Other Pacific Islander	Other race	Multiracial	Hispanic/ Latino
Franklin County	99%	—	<1%	<1%	—	<1%	<1%	1%
Frontier County	98%	<1%	<1%	<1%	—	<1%	1%	1%
Furnas County	98%	<1%	<1%	<1%	—	<1%	1%	1%
Gage County	98%	<1%	1%	<1%	<1%	<1%	1%	1%
Garden County	98%	<1%	<1%	<1%	—	1%	<1%	1%
Garfield County	99%	—	<1%	<1%	<1%	<1%	1%	1%
Gosper County	99%	—	<1%	<1%	—	<1%	<1%	1%
Grant County	99%	—	<1%	<1%	—	1%	—	1%
Greeley County	98%	1%	<1%	<1%	—	1%	<1%	1%
Hall County	89%	<1%	<1%	1%	<1%	8%	1%	14%
Hamilton County	98%	<1%	<1%	<1%	—	<1%	1%	1%
Harlan County	99%	<1%	<1%	<1%	<1%	<1%	1%	1%
Hayes County	97%	<1%	—	<1%	—	2%	1%	3%
Hitchcock County	98%	<1%	<1%	<1%	—	<1%	1%	1%
Holt County	99%	<1%	<1%	<1%	<1%	<1%	<1%	1%
Hooker County	99%	—	<1%	<1%	—	<1%	1%	1%
Howard County	99%	<1%	<1%	<1%	<1%	<1%	<1%	1%
Jefferson County	98%	<1%	<1%	<1%	<1%	1%	<1%	1%
Johnson County	94%	<1%	<1%	3%	<1%	2%	1%	3%
Kearney County	98%	<1%	<1%	<1%	<1%	1%	1%	2%
Keith County	97%	<1%	1%	<1%	—	1%	1%	4%
Keya Paha County	99%	—	<1%	—	—	—	<1%	4%
Kimball County	97%	<1%	1%	<1%	<1%	1%	1%	3%
Knox County	92%	<1%	7%	<1%	<1%	<1%	1%	1%
Lancaster County	90%	3%	1%	3%	<1%	2%	2%	3%
Lincoln County	95%	1%	1%	<1%	<1%	3%	1%	5%
Logan County	99%	<1%	1%	—	—	—	<1%	1%
Loup County	99%	—	<1%	<1%	—	<1%	<1%	2%
McPherson County	98%	—	—	<1%	—	2%	—	2%
Madison County	91%	1%	1%	<1%	<1%	5%	1%	9%
Merrick County	98%	<1%	<1%	<1%	<1%	1%	<1%	2%
Morrill County	94%	<1%	1%	<1%	—	4%	1%	10%
Nance County	98%	—	<1%	<1%	—	<1%	1%	1%
Nemaha County	98%	<1%	<1%	1%	<1%	<1%	1%	1%
Nuckolls County	99%	<1%	<1%	<1%	—	1%	<1%	1%

Table A-2, cont.

Race and Ethnicity of Population by County of Nebraska, 2000

	White	African American/ Black	American Indian and Alaska Native	Asian	Native Hawaiian and Other Pacific Islander	Other race	Multiracial	Hispanic/ Latino
Otoe County	97%	<1%	<1%	<1%	<1%	1%	1%	2%
Pawnee County	99%	—	<1%	<1%	—	<1%	1%	1%
Perkins County	98%	<1%	<1%	<1%	—	1%	<1%	2%
Phelps County	98%	<1%	<1%	<1%	—	1%	1%	2%
Pierce County	99%	<1%	<1%	<1%	<1%	<1%	<1%	1%
Platte County	94%	<1%	<1%	<1%	<1%	3%	1%	7%
Polk County	99%	<1%	<1%	<1%	—	<1%	<1%	1%
Red Willow County	98%	<1%	<1%	<1%	<1%	1%	1%	2%
Richardson County	96%	<1%	2%	<1%	—	<1%	1%	1%
Rock County	99%	—	<1%	<1%	—	<1%	<1%	1%
Saline County	93%	<1%	<1%	2%	<1%	3%	1%	7%
Sarpy County	89%	4%	<1%	2%	<1%	2%	2%	4%
Saunders County	98%	<1%	<1%	<1%	<1%	<1%	1%	1%
Scotts Bluff County	88%	<1%	2%	1%	<1%	8%	2%	17%
Seward County	98%	<1%	<1%	<1%	<1%	<1%	1%	1%
Sheridan County	88%	<1%	9%	<1%	<1%	<1%	2%	1%
Sherman County	98%	<1%	<1%	<1%	<1%	<1%	1%	1%
Sioux County	98%	—	<1%	<1%	—	1%	1%	2%
Stanton County	97%	<1%	<1%	<1%	—	1%	1%	2%
Thayer County	99%	<1%	<1%	<1%	—	<1%	1%	1%
Thomas County	99%	—	<1%	—	—	—	<1%	1%
Thurston County	46%	<1%	52%	<1%	—	1%	1%	2%
Valley County	98%	<1%	<1%	<1%	<1%	1%	<1%	2%
Washington County	98%	<1%	<1%	<1%	<1%	<1%	1%	1%
Wayne County	97%	1%	<1%	<1%	<1%	1%	1%	1%
Webster County	98%	<1%	<1%	<1%	<1%	<1%	1%	1%
Wheeler County	99%	—	<1%	—	—	1%	<1%	1%
York County	97%	1%	<1%	<1%	<1%	1%	1%	1%

Source: U.S. Census Bureau, *Race and Hispanic or Latino: 2000, Nebraska,* Census 2000 Redistricting Data (Public Law 94-171) Summary File. Available online: www.census.gov (Accessed: January 10, 2003).

Note: In this table, a dash (—) is used in lieu of "0%"

Income and Poverty

Table A-3:
Median Income (2003) and Poverty Rate (1999), by County

County	Median Income	Percent in Poverty
Nebraska	**$55,400**	**10%**
Adams County	$52,800	9%
Antelope County	$40,600	13%
Arthur County	$36,300	11%
Banner County	$46,800	11%
Blaine County	$33,200	18%
Boone County	$42,600	12%
Box Butte County	$54,700	11%
Boyd County	$35,800	16%
Brown County	$41,700	13%
Buffalo County	$53,400	10%
Burt County	$44,900	10%
Butler County	$50,400	9%
Cass County	$63,300	7%
Cedar County	$46,100	9%
Chase County	$46,400	11%
Cherry County	$41,700	14%
Cheyenne County	$41,900	10%
Clay County	$44,800	11%
Colfax County	$46,900	10%
Cuming County	$45,200	10%
Custer County	$43,300	14%
Dakota County	$52,300	11%
Dawes County	$47,500	16%
Dawson County	$48,500	11%
Deuel County	$47,000	9%
Dixon County	$49,200	9%
Dodge County	$51,400	9%
Douglas County	$63,300	10%
Dundy County	$41,800	13%
Fillmore County	$49,200	9%
Franklin County	$40,900	13%
Frontier County	$44,000	13%
Furnas County	$42,400	12%

Table A-3, cont.
Median Income (2003) and Poverty Rate (1999), by County

County	Median Income	Percent in Poverty
Gage County	$49,100	10%
Garden County	$47,300	14%
Garfield County	$38,900	15%
Gosper County	$49,500	9%
Grant County	$45,800	12%
Greeley County	$39,500	14%
Hall County	$50,400	12%
Hamilton County	$53,300	8%
Harlan County	$40,600	11%
Hayes County	$35,700	12%
Hitchcock County	$42,500	14%
Holt County	$42,300	13%
Hooker County	$38,800	12%
Howard County	$45,300	12%
Jefferson County	$46,400	10%
Johnson County	$47,000	9%
Kearney County	$50,700	8%
Keith County	$44,400	11%
Keya Paha County	$44,600	19%
Kimball County	$42,400	12%
Knox County	$40,300	15%
Lancaster County	$62,400	9%
Lincoln County	$52,800	11%
Logan County	$40,800	12%
Loup County	$28,900	16%
McPherson County	$38,900	11%
Madison County	$50,600	14%
Merrick County	$46,500	10%
Morrill County	$42,700	15%
Nance County	$43,200	14%
Nemaha County	$52,800	12%
Nuckolls County	$40,100	11%
Otoe County	$52,000	8%
Pawnee County	$40,400	13%
Perkins County	$48,200	11%
Phelps County	$50,700	9%
Pierce County	$44,400	10%
Platte County	$55,000	8%

Table A-3, cont.
Median Income (2003) and Poverty Rate (1999), by County

County	Median Income	Percent in Poverty
Polk County	$52,500	7%
Red Willow County	$45,900	11%
Richardson County	$45,900	12%
Rock County	$32,300	16%
Saline County	$53,400	8%
Sarpy County	$63,300	5%
Saunders County	$57,300	7%
Scotts Bluff County	$44,900	15%
Seward County	$59,600	7%
Sheridan County	$40,400	16%
Sherman County	$38,700	12%
Sioux County	$35,700	11%
Stanton County	$46,600	8%
Thayer County	$44,000	11%
Thomas County	$44,100	15%
Thurston County	$35,200	24%
Valley County	$41,500	13%
Washington County	$63,300	6%
Wayne County	$49,100	10%
Webster County	$42,400	10%
Wheeler County	$40,200	14%
York County	$51,400	8%

Sources: U.S. Department of Housing and Urban Development, Policy Development and Research Information Service, *Estimated Median Family Incomes for FY2003,* February 2003. Available online: www.huduser.org/datasets/il/fmr02/medians.doc (Accessed: March 3, 2003). U.S. Department of Housing and Urban Development, Policy Development and Information Research Service, *FY2002 Income Limits: Nebraska*. Available online: www.huduser.org/datasets/il/fmr02/index.html (Accessed online: January 13, 2003). U. S. Census Bureau, *Table A99-31. Estimated Number and Percent People of All Ages in Poverty by County: Nebraska 1999* (Estimates model 1999 income reported in the March 2000 Current Population Survey). Available online: www.census.gov (Accessed: January 9, 2003).

Fair Market Rents

Table A-4:
Fair Market Rents by County, 2003

County	Studio	One-bedroom	Two-bedroom	Three-bedroom
Adams County	$264	$354	$467	$586
Antelope County	$253	$343	$416	$535
Arthur County	$253	$326	$416	$532
Banner County	$253	$326	$416	$533
Blaine County	$253	$326	$416	$532
Boone County	$253	$326	$416	$532
Box Butte County	$275	$326	$416	$533
Boyd County	$253	$340	$416	$532
Brown County	$253	$326	$416	$532
Buffalo County	$273	$395	$495	$617
Burt County	$253	$326	$416	$532
Butler County	$253	$326	$416	$532
Cass County	$359	$492	$621	$814
Cedar County	$253	$326	$416	$532
Chase County	$253	$344	$416	$532
Cherry County	$253	$343	$416	$535
Cheyenne County	$283	$326	$416	$532
Clay County	$253	$326	$416	$532
Colfax County	$276	$339	$416	$532
Cuming County	$253	$344	$416	$532
Custer County	$283	$328	$416	$532
Dakota County	$365	$439	$547	$682
Dawes County	$271	$326	$416	$536
Dawson County	$278	$339	$416	$536
Deuel County	$253	$326	$416	$532
Dixon County	$282	$326	$416	$532
Dodge County	$253	$326	$429	$565
Douglas County	$359	$492	$621	$814
Dundy County	$253	$326	$416	$532
Fillmore County	$253	$326	$416	$532
Franklin County	$253	$326	$416	$537
Frontier County	$284	$326	$416	$532
Furnas County	$253	$326	$416	$532
Gage County	$253	$327	$424	$539

Table A-4, cont.
Fair Market Rents by County, 2003

County	Studio	One-bedroom	Two-bedroom	Three-bedroom
Garden County	$253	$339	$416	$535
Garfield County	$253	$326	$416	$532
Gosper County	$253	$326	$416	$532
Grant County	$253	$326	$416	$532
Greeley County	$253	$326	$416	$532
Hall County	$304	$400	$533	$701
Hamilton County	$253	$326	$416	$536
Harlan County	$253	$326	$416	$533
Hayes County	$253	$341	$416	$532
Hitchcock County	$253	$326	$416	$532
Holt County	$253	$326	$416	$532
Hooker County	$253	$341	$416	$533
Howard County	$253	$326	$416	$532
Jefferson County	$253	$326	$416	$532
Johnson County	$253	$330	$416	$532
Kearney County	$253	$326	$416	$532
Keith County	$253	$326	$416	$532
Keya Paha County	$253	$326	$416	$532
Kimball County	$253	$326	$416	$533
Knox County	$253	$338	$416	$532
Lancaster County	$334	$427	$564	$748
Lincoln County	$259	$339	$416	$532
Logan County	$253	$326	$416	$532
Loup County	$253	$326	$416	$532
McPherson County	$253	$326	$416	$533
Madison County	$259	$341	$451	$584
Merrick County	$253	$326	$416	$532
Morrill County	$253	$328	$416	$532
Nance County	$253	$326	$416	$532
Nemaha County	$253	$326	$416	$532
Nuckolls County	$253	$326	$416	$532
Otoe County	$253	$326	$416	$532
Pawnee County	$253	$326	$416	$536
Perkins County	$253	$326	$416	$532
Phelps County	$283	$326	$416	$533
Pierce County	$253	$326	$416	$532
Platte County	$253	$326	$416	$580
Polk County	$253	$326	$416	$532

Table A-4, cont.
Fair Market Rents by County, 2003

County	Studio	One-bedroom	Two-bedroom	Three-bedroom
Red Willow County	$253	$326	$416	$532
Richardson County	$253	$326	$416	$532
Rock County	$253	$333	$416	$532
Saline County	$253	$340	$416	$532
Sarpy County	$359	$492	$621	$814
Saunders County	$253	$326	$416	$532
Scotts Bluff County	$257	$338	$429	$532
Seward County	$314	$326	$425	$532
Sheridan County	$253	$326	$416	$532
Sherman County	$253	$328	$416	$532
Sioux County	$253	$326	$416	$532
Stanton County	$253	$326	$416	$532
Thayer County	$253	$343	$416	$532
Thomas County	$253	$326	$416	$532
Thurston County	$253	$326	$416	$532
Valley County	$253	$326	$416	$532
Washington County	$359	$492	$621	$814
Wayne County	$289	$326	$416	$532
Webster County	$253	$326	$416	$532
Wheeler County	$253	$326	$416	$533
York County	$253	$326	$421	$532

Source: U.S. Department of Housing and Urban Development Policy Development and Research Information Service, *Fair Market Rents 2003*. Available online: www.huduser.org/datasets/fmr.html (Accessed: January 28, 2003).

Housing Authority Inventory

Table A-5:
Housing Authority Inventory

Housing Authority Name	Public Housing	Section 8
Ainsworth	30	0
Alma	20	0
Albion	40	0
Alliance	59	137
Ansley	20	0
Auburn	51	0
Aurora	38	0
Bassett	20	0
Bayard	20	0
Beatrice	0	204
Beemer	20	0
Bellevue	51	220
Benkelman	44	0
Blair	100	29
Blue Hill	41	0
Bridgeport	20	0
Broken Bow	89	0
Burwell	73	0
Cairo	18	0
Cambridge	20	0
Central Nebraska	0	73
Chadron	0	40
Chappell	30	0
Clarkson	30	0
Clay Center	30	0
Coleridge	25	0
Columbus	100	100
Cozad	40	59
Creighton	35	0
Crete	40	25
Curtis	24	0
David City	57	0
Deshler	30	0
Douglas County	87	939
Edgar	20	0
Emerson	20	0
Fairbury	60	0
Fairmont	20	0

Table A-5, cont.
Housing Authority Inventory

Housing Authority Name	Public Housing	Section 8
Falls City	90	0
Fremont	252	133
Friend	32	0
Genoa	20	0
Gibbon	40	0
Goldenrod	0	137
Gordon	26	0
Gothenburg	68	25
Grant	20	0
Greeley	14	0
Gresham	20	0
Hall County	392	413
Harvard	24	0
Hastings	0	477
Hay Springs	20	0
Hemingford	20	0
Henderson	20	0
Hooper	25	0
Humboldt	30	0
Imperial	20	0
Indianola	25	0
Kearney	185	103
Lexington	82	122
Lincoln	320	2,874
Loup City	40	0
Lynch	16	0
Lyons	20	0
Mccook	30	73
Minden	31	0
Nebraska City	81	30
Neligh	40	0
Nelson	20	0
Newman Grove	20	0
Niobrara	20	0
Norfolk	0	254
North Loup	20	0
North Platte	250	60
Northeast Nebraska	0	73
Oakland	28	0

Table A-5, cont.
Housing Authority Inventory

Housing Authority Name	Public Housing	Section 8
Omaha Housing Authority	2,725	4,053
Ord	118	0
Oshkosh	20	0
Oxford	20	0
Pawnee City	64	0
Plattsmouth	60	0
Ravenna	20	0
Red Cloud	55	0
Sargent	20	0
Schuyler	59	0
Scotts Bluff County	162	410
Shelton	20	0
South Sioux City	0	235
St. Edward	20	0
St. Paul	40	0
Stanton	30	0
Stromsburg	36	0
Sutherland	20	0
Syracuse	24	0
Tecumseh	24	0
Tekamah	26	0
Tilden	20	0
Verdigre	20	0
Wayne	38	0
Weeping Water	20	0
West Central Nebraska	0	155
Wilber	30	0
Wood River	20	0
Wymore	30	0
York	82	99
Total	**7,606**	**11,552**

Sources: Housing Authority Low Rent Inventory and Section 8 vouchers are available from the U.S. Department of Housing and Urban Development's Public and Indian Housing (PIH) Information Center (PIC). Available online: www.hud.gov/offices/pih/systems/pic/haprofiles/index.cfm (Accessed: June 4, 2003).

Notes: Housing Authority inventory information has not been independently verified by AIDS Housing of Washington. Inventory represents the resources of the housing authority, not the availability of these resources. "Low rent units" represent public housing inventory, per PIC Help, email communication with AHW, October 16, 2002.

Appendix III: Survey Data

The following pages present complete survey data from the Nebraska HIV/AIDS 2002 Statewide AIDS Housing Needs Assessment survey of consumers and selected survey results from the Ryan White Client Satisfaction Survey, 2001. Analysis of this data can be found in the "Survey Findings" section of the plan.

2002 Statewide AIDS Housing Needs Assessment

This survey was conducted by the Nebraska Department of Health and Human Services (NHHS) and the Nebraska AIDS Project (NAP), and completed by February 25, 2002. The data was analyzed and reviewed by AIDS Housing of Washington. A dash (—) is used in lieu of zero (0).

Demographics

Family Composition

Number	Percent	Option
121	**56%**	Single adult male
23	**11%**	Single adult male with children
22	**10%**	Single adult female
17	**8%**	Single adult female with children
16	**7%**	Youth (under 18 years not living with parent or guardian)
8	**4%**	Couples/partners, no children
8	**4%**	No response
—	**—**	Couples/partners, with children

Age of Respondents

Number	Percent	Option
—	**—**	Under 18 years
*****	**1%**	18 to 20 years
20	**9%**	21 to 29 years
77	**36%**	30 to 39 years
74	**34%**	40 to 49 years
25	**12%**	50 to 59 years
10	**5%**	60 years and over
8	**4%**	No response

*Total number of respondents is three or less. Numbers less than 4 are not included to protect the privacy of individuals with HIV/AIDS.

Race/Ethnicity

Number	Percent	Option
150	**70%**	White/Caucasian
43	**20%**	Black
19	**9%**	Hispanic
*****	**1%**	Native American
*****	**1%**	Other
—	**—**	Asian/Pacific Islander
—	**—**	Multiracial

*Total number of respondents is three or less. Numbers less than 4 are not included to protect the privacy of individuals with HIV/AIDS.

Gender

Number	Percent	Option
158	**74%**	Male
49	**23%**	Female
8	**4%**	No response

Medical Coverage

Number	Percent	Option
73	**34%**	No health care coverage
47	**22%**	Privately insured
39	**18%**	Covered by Medicaid
37	**17%**	Covered by both Medicare and Medicaid
19	**9%**	Covered by Medicare

County

Respondents were asked to write in their county.

Number	Percent	Option
113	**53%**	Douglas
28	**13%**	Lancaster
8	**4%**	Buffalo
8	**4%**	Hall
6	**3%**	Scotts Bluff
4	**2%**	Madison
35	**16%**	Other Counties*
13	**6%**	No response

*Other counties include: Adams, Antelope, Box Butte, Brown, Cass, Cedar, Clay, Custer, Dakota, Dawson, Dodge, Duel, Gosper, Lincoln, Platte, Saline, Sarpy, Valley, and Wayne.

Gross Monthly Income

Respondents were asked to choose one of the following ranges of gross monthly income.

Number	Percent	Option
37	**17%**	$0 to $250
23	**11%**	$251 to $500
81	**38%**	$501 to $1,000
45	**21%**	$1,001 to $1,500
7	**3%**	$1,501 to $2,000
9	**4%**	$2,001 to $2,500
6	**3%**	$2,501 to $3,000
7	**3%**	$3,001 and up

Sources of Income

Respondents could check more than one.

Number	Percent	Option
72	**33%**	Social Security Disability Income (SSDI)
52	**24%**	Full-time employment
30	**14%**	Supplemental Security Income (SSI)
23	**11%**	Part-time employment
18	**8%**	No response
16	**7%**	Unemployment
12	**6%**	Retirement/pension
5	**2%**	Savings
2	**1%**	Temporary Assistance for Needy Families (TANF)
—	**—**	Life insurance proceeds
—	**—**	Temporary employment
15	**7%**	Other (specify)

Of the 13 respondents who checked "other," one each wrote:

- ADC
- Dep on parents
- Family
- General assistance
- Partner
- RR disability
- Unemployment
- VA benefits

Two indicated they were self-employed, and 3 indicated "none."

Number in Household

Respondents were asked for the number in their household in a few categories, and asked to include themselves in the count.

People under 18 with HIV in household:

- None reported

People under 18 with AIDS in household:

- 1 respondent reported 1 person

People under 18 without HIV/AIDS in household:

- 6 respondents reported 1 person
- 3 respondents reported 3 people
- 1 respondent reported 5 people

Total number of people under 18 in household (tabulated by AIDS Housing of Washington):

- 7 respondents reported 1 person
- 3 respondents reported 3 people
- 1 respondent reported 5 people

People 18 and over with HIV in household:

- 147 respondents reported 1 person

People 18 and over with AIDS in household:

- 74 respondents reported 1 person

People 18 and over without HIV/AIDS in household:

- 26 respondents reported 1 person
- 1 respondent reported 4 people

Total number of people 18 and over in household (tabulated by AIDS Housing of Washington):

- 182 respondents reported 1 person
- 29 respondents reported 2 people
- 2 respondents reported 3 people
- 1 respondent reported 5 people

The number in household reported by men and women was very similar. The majority—82 percent of men and 77 percent of women—reported living alone. The average household size reported by men was 1.27, compared to 1.33 for women.

Transportation

Respondents were asked to check no more than the two which most apply.

Number	Percent	Option
108	**50%**	A functioning car
47	**22%**	Access to public transportation
38	**18%**	Access to transportation only through friends
24	**11%**	A car not functioning due to repair needs
18	**8%**	Access to a car
16	**7%**	Access to transportation only through a case manager

HIV/AIDS Status

In what year did you first test HIV-positive?

Number	Percent	Year
28	**13%**	1983–1989
14	**7%**	1990
7	**3%**	1991
10	**5%**	1992
12	**6%**	1993
9	**4%**	1994
7	**3%**	1995
16	**7%**	1996
20	**9%**	1997
21	**10%**	1998
16	**7%**	1999
14	**7%**	2000
27	**13%**	2001
2	**1%**	2002
12	**6%**	No response

In what state [did you first test HIV-positive]?

Number	Percent	State
149	**69%**	Nebraska
7	**3%**	Texas
6	**3%**	California
6	**3%**	Iowa
5	**2%**	Colorado
5	**2%**	North Carolina
3	**1%**	Florida
3	**1%**	Illinois
3	**1%**	Kansas
3	**1%**	Utah
2	**1%**	Massachusetts
2	**1%**	Missouri
2	**1%**	Nevada
2	**1%**	South Dakota
2	**1%**	Washington
1	**1%**	Arkansas
1	**1%**	Georgia
1	**1%**	Hawaii
1	**1%**	Minnesota
1	**1%**	Oklahoma
1	**1%**	Outside the United States
9	**4%**	No response

Indicate the number of hospital admissions you've had for HIV/AIDS-related reasons since testing positive.

Number	Percent	Number of Hospitalizations
114	**53%**	None
38	**18%**	One
24	**11%**	Two
10	**5%**	Three
5	**2%**	Four
2	**1%**	Five
3	**1%**	Six
1	**1%**	Seven
3	**1%**	Eight
—	**—**	Nine
6	**3%**	Ten to fifteen
5	**2%**	Sixteen to twenty
4	**2%**	More than twenty

During 2001 [indicate the number of hospital admissions you've had for HIV/AIDS-related reasons].

Number	Percent	Number of Hospitalizations During 2001
169	**79%**	None
21	**10%**	One
15	**7%**	Two
7	**3%**	Three
—	**—**	Four
1	**1%**	Five
—	**—**	Six to nine
2	**1%**	Ten to twelve

Housing Information

Current Living Situation

Number	Percent	Option
97	**45%**	Rental housing
38	**18%**	Homeowner
32	**15%**	Living with friends or relatives
14	**7%**	In a room of a house shared with non-related individuals
14	**7%**	Section 8 rental assistance
9	**4%**	Other subsidized housing (specify program) (see below)
2	**1%**	Living in a hospital or nursing home
2	**1%**	Living on the streets, in car, in parks, etc.
2	**1%**	Other (one wrote "lo income-not subsidized" and one wrote "prison")
1	**1%**	Living in a transitional housing facility
—	**—**	Living in an emergency shelter

Respondents who indicated "other subsidized housing" specified the following types:

- Douglas Co Housing
- Housing
- HUD
- OHA (2 respondents)
- Omaha Housing
- Public housing
- Senior citizen tower
- Tower

Generally, the current living situation of men and women was fairly similar. Women were somewhat more likely to have Section 8 than men (14 percent compared to 4 percent), while men were somewhat more likely to be living with friends or relatives (17 percent compared to 8 percent).

During the last twelve (12) months have you resided in or experienced any of the following situations:

Number	Percent	Option
70	**33%**	Needed financial assistance to prevent heat or utilities from being cut off
60	**28%**	Needed financial assistance to prevent homelessness
50	**23%**	Moved in with friends or relatives
47	**22%**	Phone service cut off
41	**19%**	Let other people move in to help pay expenses
39	**18%**	Had to sell car or other personal belongings to pay expenses
36	**17%**	Hospitalized for HIV/AIDS-related diseases
33	**15%**	Faced eviction
30	**14%**	Heat or utilities cut off
21	**10%**	Moved because couldn't pay rent
16	**7%**	Experienced domestic violence or intimate partner abuse
15	**7%**	Harassed by neighbors, landlord, etc., to the point of having to move
13	**6%**	Stayed in a psychiatric facility
13	**6%**	Was in jail or prison
11	**5%**	Spent more than one night sleeping in car, on streets, etc.
9	**4%**	Stayed in an emergency shelter
7	**3%**	Stayed in a substance use treatment facility
4	**2%**	Denied housing due to HIV status
4	**2%**	Lived in a transitional housing facility

How much do you pay monthly for housing, including utilities?
Respondents wrote in the actual monthly payment; the following presents the amount by range:

Number	Percent	Ranges
25	**12%**	None
1	**1%**	$1 to $100
8	**4%**	$101 to $200
31	**14%**	$201 to $300
33	**15%**	$301 to $400
22	**10%**	$401 to $500
60	**28%**	$501 to $750
19	**9%**	$751 to $1,000
14	**7%**	$1,001 or more
2	**1%**	No response

The median amount reported was $400, meaning half of respondents paid more and half paid less. The least reported was $0 and the most was $3,400.

Respondents were asked to report the **percentage of their income that they spend on housing**. Reported percentages fell into the following ranges:

Number	Percent	Percent of Income Spent on Housing Costs
85	40%	30% or less
50	23%	31% to 50%
78	36%	More than 50%

*2 respondents (1%) did not answer the question.

The average amount of income spent on housing reported was 43 percent, while the median was 50 percent. The lowest proportion of income spent on housing was none, while the highest was 167 percent. Because respondents were not asked to report all the sources of funding paying for housing, it is unclear where funds above 100 percent of income came from.

How many times have you moved over the last twelve (12) months?

Number	Percent	Option
142	**66%**	No moves
39	**18%**	One
16	**7%**	Two
8	**4%**	Three
5	**2%**	Four
3	**1%**	Five
1	**1%**	Seven
1	**1%**	Eight

Respondents were asked to write in the reasons for their move(s). At least 12 reported financial reasons such as "couldn't pay rent" and "had to cut living expenses." Five cited problems with a landlord, and 2 had been evicted. Two cited their partner's substance use, and 1 cited "alcohol, drug addiction." Finally, 8 moved to improve their situation, citing reasons such as "bigger place," "bought a house," "more livable space," and "warmer housing."

Since testing positive, have you ever experienced homelessness? (living in car, park, homeless shelter, motel, doubled up with friends or relatives, etc.)

Number	Percent	Option
84	**39%**	Yes
131	**61%**	No

Do you feel you have been discriminated against regarding housing based on sexual orientation?

Number	Percent	Option
31	**14%**	Yes
184	**86%**	No

Do you feel it would jeopardize your housing if you disclosed your status to your landlord, mortgage company, or housing provider?

Number	Percent	Option
84	**39%**	Yes
131	**61%**	No

Have you ever tried to access any public housing authority or other entity to pay a portion of your rental expenses?

Number	Percent	Option
83	**39%**	Yes
132	**61%**	No

Does any public housing authority or other entity pay a portion of your rental expenses on an ongoing basis?

Number	Percent	Option
25	**12%**	Yes
190	**88%**	No

If no, are you currently on the public housing authority's waiting list to receive help with your rent?

Number	Percent	Option
8	**4%**	Yes
207	**96%**	No

Mental Health/Substance Abuse Needs

Have you ever tried to access mental health services?

Number	Percent	Option
86	**40%**	Yes
129	**60%**	No

Were you successful?

Number	Percent	Option
74	**34%**	Yes
141	**66%**	No

Respondents who had not been successful were asked to give the reason. Each of the following reasons was given by a respondent:

- Backed up
- Didn't help
- HIV status
- Only wanted to give pills
- Still working
- Transportation

Were you put on a waiting list?

Number	Percent	Option
8	**4%**	Yes
207	**96%**	No

Respondents who were put on the waiting list were asked for the amount of time. Each of the following periods was given by respondents:

- Several weeks
- 1 month
- Months
- 1 year
- 18 months

Have you tried to access substance abuse services?

Number	Percent	Option
32	**15%**	Yes
183	**85%**	No

Were you successful?

Number	Percent	Option
28	**13%**	Yes
187	**87%**	No

Respondents who were not successful were asked for the reasons why. The only response given was "felt [treatment was] verbally abusive."

Were you put on a waiting list?

Number	Percent	Option
7	**3%**	Yes
208	**97%**	No

Respondents who were put on a waiting list were asked for the length of the list. Each of the following periods was given by respondents:

- 14 days
- Several weeks
- 3 weeks
- 6 months
- 9 months
- 20 months

Respondents who reported having tried to access substance use treatment were much more likely to report prior housing problems than respondents who had not tried to access substance use treatment. Although the small number of people involved makes it difficult to generalize, evidence of more housing problems among people with substance use issues is consistent with trends documented nationally as well as anecdotal information. Specifically, people who had tried to access substance use treatment were more likely to have:

- Stayed in a shelter in the last 12 months (9 percent versus 3 percent for those who hadn't tried to access substance use treatment)
- Spent more than one night sleeping in a car, on the streets, etc. (13 percent versus 4 percent)
- Been in jail or prison (19 percent versus 4 percent)
- Faced eviction (25 percent versus 14 percent)

Additional Comments

Respondents were asked to share anything else they thought important about their housing situation. The comments below were grouped by theme identified by AIDS Housing of Washington. Some comments deal with more than one theme, but each is listed only once. Comments appear as they were received; they have not been edited.

Housing Assistance

- Ongoing intimidation. Continual invasion of privacy (OHA "need to enter") on an average of at least 12–24 times per year. Severe security problems.
- called section 8, no contact, 8 month waiting, not on any list yet
- can I get a section 8 house
- Hope to be on waiting list for public housing authority soon
- I live on Section 8 comfortable
- no list available at time or last 12 months—told by Sec 8 housing
- NAP helped me once in 1999 with my house rent $350 Thank God!!
- public housing not available in our town. Will probably move next month because it is costing too much to live here
- The rental assistance program is really a HELPFUL thing. A yearly basis type assistance would be very beneficial. Help with utilities is a great help especially during the mid winter months and very hot day.

Housing Assistance from Family

- Do not qualify for housing authority cause I rent from a relative
- currently living with sister and brother in law with their baby so living space is not enough for all of us
- I have a partner who owns our home so above really hasn't been a factor
- I live with my life partner who supports the household minus my contributions
- I rent from my sister—but I would never tell a stranger landlord my medical status—of course they would discriminate
- rent house—daughter moved in to take care of Dad. Need help with purchase of medications.
- If I didn't have a grandmother, I would be homeless right now. And since this is a Senior's apartment, I have to leave.
- If not for my family I would be destitute
- Living with parents till April then moving back to Texas.

- It would be nice to access planning information to facilitate moving into rental outside the family

Confidentiality and HIV/AIDS-Related Stigma

- Even in Lancaster county, this has happened to me 2 yrs ago, a landlord tried to deny me housing because of my HIV status.
- have fear of being evicted when sick for not paying my rent and fear of eviction if people know
- I feel better living in OHA than other places that judge you because of HIV
- I will never tell anyone beside my family and doctor of my status with HIV. It is not their business.
- I live with my parents because I don't have enough money for my living and meds. Rent help is something I could use
- Our landlords partner died of AIDS. That is why no discrimination. If NHHS knew we lived together (me on benefits and partner working) they would cut off my much-needed benefits. That is not fair to us

Other Housing Needs

- heating cost is up in summer and winter
- I can't afford medical and rent and utilities
- Homeowners are hurting just to pay mortgages, utilities, phone, etc. We are trying to keep our homes so we do have a place to live.
- Nobody want to help if you have a mortgage but is it actually less for me than renting. Not make any sense
- AIDS related neuropathy lots of stairs in the house. Sometimes I use a walker or cane to get around
- I am now living in my own apt but financial situation is tight
- I can't get on the list right now cause we make to much money
- I get $10 in food stamps and don't have cash for food
- I need help for housing, car repair, school money, college
- I truly need help to keep a roof over my head.
- I will need help with housing in the next 3 to 6 months
- Needing furniture
- Now in process of being evicted, have to be out by March 1
- OHA puts people sick and week in with low income dwellings who can [illegible] us
- Rent is high in clean neighborhood. I must live in a dangerous neighborhood in order to afford rent & I am living next door to black gangs that have drive by shooting, am afraid for the safety of my family
- This is the first time I attempt to get my own place and will help in some form
- would like to move to better location
- please have someone contact me regarding help for housing

Accessing Physical and Behavioral Health Care

- have received a 60 day notice to vacate apt. will be residing in temporary shelter until other housing arrangements can be secured paid bills success mental health dx—major depression w/ psychotic features. Discontinued MH tx, may resume contact with in the future and group day program
- When I had insurance & a job after I was diagnosed, I checked myself into St. Joes. Mental health center for anxiety and depression. 2 month inpt 1 month outpt—ongoing counseling since that time
- Need transportation to and from mental clinic
- mental health was not any help and not interested in real reasons for depression
- I think people on Medicaid could use help with co-pays. Sometime you just don't have enough money.

Other Comments

- I can't keep
- I currently reside in a facility that is somewhat ignorant in the total care of an HIV infected individual
- I live in a college dorm so I may not be the best responder
- Take my name off your list. As I told NAP their help was worthless. I'd rather die early by working myself to death rather than get any help from them or the government. You only help worthless people who aren't even trying to help themselves
- transportation
- undocumented
- Want to be informed and have available help if I should ever need it. ?VA
- Thank you I hope this helps

Ryan White Client Satisfaction Survey

A Ryan White Title II- and Title III-funded programs client satisfaction survey was conducted in the fall of 2001. Client addresses were submitted from the State Title II program, both Title III programs, ADAP, and Nebraska AIDS Project, then collated by the State Title II Program Manager. Duplicate addresses were reviewed to attempt to send surveys to the most recent client address. Five hundred surveys (including 30 surveys translated into Spanish) were sent out to clients statewide. Eighty-eight surveys (17 percent) were returned unopened and non-deliverable. A total of 125 surveys (25 percent) were completed and returned, including 8 in Spanish.

The majority of the survey focused on client satisfaction with Ryan White-funded services. Some questions dealt with need for and access to services. Selected information regarding needs and accessibility of services is presented here.

Mental Health and Substance Use Services

You were able to get mental health services (counseling, support groups, etc.) without any trouble in your area.

Percent	Option
43%	Agree
10%	Somewhat Agree
9%	Disagree
38%	Did Not Use/Doesn't Apply

You were able to get substance abuse treatment in your area without any trouble.

Percent	Option
13%	Agree
5%	Somewhat Agree
7%	Disagree
75%	Did Not Use/Doesn't Apply

Case Management

Mark all the services listed below that you have received through a case manager in the past 12 months.

Number	Percent	Option
49	**39%**	No services
32	**26%**	Utilities
28	**22%**	Housing
27	**22%**	Food
24	**19%**	Transportation
19	**15%**	Insurance

Clients who must travel to obtain services were asked **how far they must travel (one way) to a number of services.** The following is a breakdown per service category indicating the number of miles clients travel to services and the percentage of clients based on the number of responses (n) received:

Services	Miles Traveled One Way						
	<10	**10-20**	**21-45**	**46-75**	**76-100**	**101-150**	**151+**
Case Manager (n=92)	58%	11%	18%	8%	3%	1%	—
Dental Care (n=84)	70%	13%	6%	4%	6%	1%	—
Drug/Alcohol Treatment (n=12)	58%	25%	17%	—	—	—	—
Food Bank (n=32)	59%	13%	22%	17%	—	—	—
Medical Care (n=113)	56%	12%	10%	6%	5%	4%	6%
Mental Health (n=41)	61%	15%	12%	7%	2%	2%	—
Other Social Services (n=17)	35%	41%	18%	6%	—	—	—
Support Group (n=54)	57%	4%	31%	4%	4%	—	—

Appendix IV: Nebraska HIV/AIDS 2002 Statewide AIDS Housing Needs Assessment Tool

Survey Tool Introduction: We want to help with your housing needs! To do this, Nebraska Department of Health and Human Services (NHHS) and the Nebraska AIDS Project (NAP) are submitting an application for a Housing Opportunities for Persons With AIDS grant from the U.S. Department of Housing and Urban Development. Your participation in this needs assessment is vital to the success of our application! This information will be used to identify and prove housing needs for people with HIV/AIDS in Nebraska. All information will be kept confidential and utilized in a summary format. We DO NOT want you to identify yourself anywhere in this survey. If you have questions regarding the survey, please call Judy Hughes-Anderson (NHHS) at 402-471-0937 or Erin Porterfield (NAP) at 402-552-9260 or 1-800-782-AIDS. Please return this survey in the attached Business Reply Envelope by February 25, 2002

Demographics

Family Composition:

____Single Adult Male
____Single Adult Female
____Couples/Partners, no children
____Youth (under 18 years not living with parent or guardian)
____Single Adult Male with children
____Single Adult Female with children
____Couples/Partners, with children

Age of Respondent:

____Under 18 years ____18 to 20 years ____21 to 29 years ____30 to 39 years
____40 to 49 years ____50 to 59 years ____60 years and over

Race/Ethnicity:

___White/Caucasian ____Hispanic ____Black ____Native American
___Asian/Pacific Islander ____Multi-racial ____Other

Gender:

____Male ____Female

Medical Coverage:

____Privately Insured
____Covered by Medicaid
____Covered by Medicare
____No Health Care Coverage

County: _____

(This is important information to determine geographic needs.)

Gross Monthly Income:

____0 to $250
____$251 to $500
____$501 to $1000
____$1001 to $1500
____$1501 to $2000
____$2001 to $2500
____$2501 to $3000
____$3001 and up

Sources of Income:

____Full-time Employment
____Part-time Employment
____Temporary Employment
____Unemployment
____Retirement/Pension
____Social Security Disability (SSDI)
____Supplemental Security Income (SSI)
____Temp Assistance for Families (TANF)
____Savings
____Life Insurance Proceeds
____Other (Specify)_____

Family Information:
Number in Household:
(include self)

____Under 18 with HIV
____Under 18 with AIDS
____Under 18 without HIV/AIDS
____18 and over with HIV
____18 and over with AIDS
____18 and over without HIV/AIDS

HIV/AIDS Status:

In what year did you first test HIV positive?
_____ In what state? _____
Indicate the number of hospital admissions you've had for HIV/AIDS related reasons since testing positive?_____
During 2001?_____

Transportation:
(check **no more than two** which most apply)
Do you have:

____a functioning car
____a car not functioning due to repair needs
____access to a car
____access to public transportation
____access to transportation only through friends
____access to transportation only through a case manager

Housing Information

Current living situation:

____Homeowner
____Rental Housing
____Section 8 Rental Assistance
____Other Subsidized Housing (Specify Program_____)
____Living with friends or relatives
____Living in a Transitional Housing Facility
____Living in an Emergency Shelter
____Living on the streets, in car, in parks, etc.
____Living in a hospital or nursing home
____In a room of a house shared with non-related individuals
____Other (Please specify)_____

During the last twelve (12) months have you resided in or experienced any of the following situations:
____Stayed in an emergency shelter
____Spent more than one night sleeping in car, on streets, etc.
____Lived in a Transitional Housing Facility
____Moved in with friends or relatives
____Stayed in a Substance Abuse Treatment Facility
____Stayed in a Psychiatric Facility
____Hospitalized for HIV/AIDS related diseases
____Was in jail or prison
____Experienced domestic violence or intimate partner abuse
____Faced Eviction
____Moved because couldn't pay rent
____Denied housing due to HIV status
____Harassed by neighbors, landlord, etc. to the point of having to move
____Heat or utilities cut off
____Needed financial assistance to prevent heat and utilities from being cut off
____Phone service cut off
____Let other people move in to help pay expenses
____Had to sell car or other personal belongings to pay expenses
____Needed financial assistance to prevent homelessness

- How much do you pay monthly for housing, including utilities? $_____
- What percentage of your total income is spent on housing and utility costs? _____%
- How many times have you moved over the last twelve (12) months? _____
  Why? _____
- Since testing positive, have you ever experienced homelessness? (living in car, park, homeless shelter, motel, doubled up with friends or relatives, etc.) _____Yes _____No
- Do you feel you have been discriminated against regarding housing based on sexual orientation? _____ Yes _____ No
- Do you feel it would jeopardize your housing if you disclosed your status to your landlord, mortgage company, or housing provider? _____Yes _____ No
- Have you ever tried to access any public housing authority or other entity to pay a portion of your rental expenses? _____Yes _____No
- Does any public housing authority or other entity pay a portion of your rental expenses on an ongoing basis? _____Yes _____No
- If No, are you currently on the public housing authority's waiting list to receive help with your rent? _____Yes _____No

Please comment on anything else you would like us to know in regards to your housing situation:
_____

Mental Health/Substance Abuse Needs

1. Have you tried to access mental health services? _____ Yes _____ No
   Were you successful _____ Yes _____ No If No, Reason: _____
   Were you put on a waiting list _____ Yes _____No If Yes, how long: _____

2. Have you tried to access substance abuse services? _____ Yes _____ No
   Were you successful _____ Yes _____ No If No, Reason: _____
   Were you put on a waiting list _____ Yes _____No If Yes, how long: _____

Appendix V: Consumer Focus Group Summaries

Focus groups were held with people living with HIV/AIDS in Nebraska to get more perspective on housing needs and preferences. This section contains summaries of each focus group. In addition, a focus group was scheduled in Fremont, but nobody participated.

Omaha

Summary of Results from Dining Room Focus Group
February 28, 2003

Participant Demographics and Background

Gender Identification: 11 men and 1 woman

Racial Identification: 8 African American, 2 White/Caucasian, 1 Hispanic/Latino, and 1 unknown

Housing Situation

Participants were asked to introduce themselves and to describe their housing situation. The following housing situations were mentioned:

- Participant is living with his/her mother. "I want to get my own housing, but I owe back rent at the Towers and can't pay the back rent."
- Participant is living in a weekly hotel. Has faced a lot of discrimination, especially because of lack of income. Has been denied Social Security and General Assistance.
- Participant has a Section 8 voucher for a two-bedroom apartment. Pays a family member to be a caretaker.
- Participant lives with his/her partner who owns a home and would like to leave that living situation, but cannot afford to. Came to Omaha from another state and the resources are more limited here.
- Participant's credit was ruined due to unmanageable medical bills. Currently lives with sister.
- Participant is on General Assistance and lives in an apartment. NAP provides some support.
- Participant lives with a friend and cannot find another place.
- Participant was denied disability. For the time being s/he is staying with a friend. One challenge is that there are different rules about eligibility for various programs. "I might look healthy, but…"
- Participant owns a home and is still working. Feels stable.
- Participant lives alone in an apartment. A church pays the rent.
- Participant lives alone in an apartment. Getting unemployment now, but is worried what will happen when that ends.
- Participant owns a home and feels stable in housing.

Need for Housing and Related Assistance

Participants discussed issues related to housing stability, including challenges they faced in the past and assistance that they needed to stay in housing.

- There are limited resources, which is a concern for participants. Some participants expressed concern that in other cities and states services/resources had been abused/misused and that this further limits the availability of resources.
- Limitations on resources are not clearly articulated. Participants indicated they were not educated about what is possible. Some feel that animosity is growing between consumers and providers. "All of us have even given up asking because we are told that no funds are available."
- Some participants felt a lot of stress due to worries about housing. Specific comments included:
  - "I shouldn't have to wait until I am damn near dead to get assistance."
  - "I feel like I have to beg."
  - "Imagine how many people have struggled and strived for assistance."
- Deposits and move-in costs can be a problem.
- Illness can hinder access to services. For some types of assistance, a consumer must go to the office to check in with staff. For people who are sick, this can be a problem.
- Background checks for criminal history, including drug use, can be a barrier to accessing housing. "They keep you on the ropes around here."
- A participant who had a Section 8 voucher commented that Section 8 allows flexibility and choice.
- A participant commented that if you are in need of housing, you worry that you will have to wait for a long time and that you really cannot afford to, given your health status. S/he was able to get housing assistance quickly, although s/he had thought s/he would need to wait.

Experiences of Discrimination

Participants discussed issues related to stigma and discrimination. Comments included:

- Participants have experienced that many landlords do not want to rent to someone receiving General Assistance, or will not accept Section 8 vouchers. One reason offered was that payments take too long.
- "I haven't heard of or seen discrimination."

Recommendations for HIV/AIDS Housing

Participants were asked to share their priorities and recommendations for HIV/AIDS housing. The following recommendations were offered:

- Many participants supported having a staff position at Nebraska AIDS Project dedicated specifically to helping people address housing issues and find low-cost housing options. "You need support to be able to get housing."
- It was recommended that rental assistance be available that was not attached to certain housing projects.
- Some suggested having special contacts in other systems to facilitate access to services and providing special resources for people who are HIV-positive. Some wanted the primary point of access for any needed service to be the HIV system. However, one participant felt differently from the majority and expressed his/her opinion that people should not use HIV as an excuse or a crutch.
- Some participants felt there is a need for clear guidelines and expectations for available resources that would help ensure equal access but not overuse of the limited resources.

- Some people need help with money management.
- People need education about HIV.
- "Give people some dignity. People are going down a bad road."
- "Transportation is my problem. I'm satisfied with my housing."

Omaha

Summary of Results from Board Room Focus Group
February 28, 2003

Participant Demographics and Background

Gender Identification: 10 men and 2 women

Racial Identification: All White/Caucasian

Housing Situation

Participants were asked to introduce themselves and to describe their housing situation. The following housing situations were mentioned:

- Four participants received subsidized housing due to their HIV status.
- Three participants lived in apartments on their own.
- Two participants lived in their own homes.
- One participant shared housing.
- One participant shared an apartment with a parent.
- One participant was staying with a friend.

Participants offered additional comments about their housing situation:

- One person receives $550 per month and lives in subsidized housing. Monthly expenses are $275. Transportation costs are $80 each month, leaving $195 for food and all ancillary expenses. "If one minor crisis happens, I'm out of luck."
- One homeowner ends every month with a $600 deficit and every month is forced to gain support from family and friends. S/he fears s/he will eventually lose his/her home.
- "There is just no getting ahead when you live with this virus."
- "You can sleep in your car, but you can't drive your house."
- "More than anything, I could handle this disease and manage my life better if I knew I had a place to call home."
- Five participants indicated that their current housing was the best housing they have ever had. One had spent twenty years living in the same place. Another identified their best housing situation as a home shared with a former spouse.

Undesirable Housing Situations and Characteristics

Participants discussed undesirable housing situations and aspects of housing. The following were discussed:

- Concerns about the quality of housing: roach infested, substandard unit with no bathroom. Some will not live at the high-rise towers; they are concerned that the units are roach infested.
- Units that are too small, and/or too expensive
- Units in the "wrong" location

Participants also identified their worst housing situations:

- Two identified being homeless: one was due to sale of the unit by the landlord; the other was currently homeless and sleeping in a car
- Living in a substandard building
- Faith-based home, with a mortgage, in rough neighborhood filled with violence—unsafe
- Financial: rent was $500 and income was $480
- Shared housing with three other people in warehouse with no bathroom

Health and Housing Concerns

Participants discussed issues that caused them stress that were related to or resulting from their concerns about housing, including:

- Bills that cannot be paid
- Utility costs: some have increased 100 percent in one month
- Homeless, living in car
- Unable to work
- A crisis in health care like broken bones or need for surgery that is not covered by insurance
- Health declining and no outside support to help
- Waiting lists to get into housing
- Food and medicine make you ill
- "Who cares about medication when you don't have a home?"

Housing and Related Assistance

Participants identified services that they needed to stay in housing:

- Phone service to support mental health and avoid the feelings of isolation
- Internet access to help with connection to people and information
- Support with daily living like cleaning and cooking
- Insurance assistance
- Home health care

Participants offered the following comments about services that are available to community members:

- Medical care for HIV is fully available; there is great medical care for all.
- Some participants felt there is ample support for those who want drug treatment, and that there is no need to spend any more on treatment services.

Barriers to Accessing Care

Participants identified barriers to accessing care:

- Inadequate linkage to social workers and knowledge about how to seek assistance for those who are homeless
- Lack of understanding about what resources are available
- Stress involved with fear of losing housing
- Rely on friends and neighbors to stay housed in order to avoid asking for assistance
- Out of work: cannot even afford the bus fare to seek job, health care, or support
- No income: has not worked in three months
- No resource for mental health support/care; not nearly enough mental health services

Recommendations for HIV/AIDS Housing

Participants were asked to share their priorities and recommendations for HIV/AIDS housing. The following recommendations were offered:

- Develop an easy-to-read resource guide.
- When asked how much assistance a month would be needed to avoid ongoing stress, the group responded with $275, $300, $500.
- The group would love to have food vouchers in addition to the food bank as another resource.
- Educate consumers about how Medicaid spend-down works to increase understanding of program.
- Develop a housing program in a large apartment complex with on-site support staff.
- Develop scattered-site apartments and homes not identified as HIV housing.
- The location of housing is critical; near bus lines and close to services is preferred.
- Support people to stay in current housing.
- Pay attention to the ADA and issues of mobility when you develop housing.
- "Without housing, we are more likely to turn to sex, drugs, and liquor." (Housing reduces these activities.)

Norfolk

April 3, 2003

Participant Demographics and Background

Gender Identification: 2 men and 1 woman

Racial Identification: 2 White/Caucasian and 1 Hispanic/Latino

Age: All late 30s

Housing Situation

Participants were asked to introduce themselves and to describe their housing histories since learning of their HIV status.

- One participant was living in northern Nebraska when s/he found out that s/he was HIV-positive. The landlord called the city inspector to have the house condemned so the family would have to move. Lived with parents for a while, and then found a house in a small town. Once again, faced discrimination as the landlord evicted the family when he found out about the tenant's HIV status. Now lives with his/her children in a two-bedroom house in a town some distance from Norfolk.
- One participant was renting an apartment when s/he found out that s/he was HIV-positive. Participant moved a number of times in the years following: first to Omaha for health care and to find a job, then to southern Nebraska to live with friends, then to another city for two years, then to halfway houses for 18 months. Currently lives alone in a two-bedroom apartment renting for $420 per month with no rental subsidy.
- One participant was living with partner when s/he found out about HIV status. It took eight months to obtain disability. Now lives alone and rents a small two-bedroom apartment.

Need for Housing and Related Assistance

Participants discussed issues related to housing stability, including challenges they had in the past and assistance that they needed to stay in housing:

- The overall cost of housing is an issue. It is too expensive to try to get a unit that is not a "rat trap."
- Language can be a barrier. The perception is that Sudanese and Spanish speakers are impacted.
- People need financial assistance when they become ill. "You have to prove each and every time with a doctor's statement that you need assistance. Well, if you are ill, it is difficult to obtain all the documentation you need."
- Housing for families is difficult to find. Three- and four-bedroom houses are not available.
- Utilities can be as high as $160 per month in addition to rent. There is not enough financial assistance available.
- The monthly lunches are good. Some people need more social support. One participant has family responsibilities that would get in the way of accessing more support if it were available. One participant is not at all open about his/her status—people do not know. The other participant has many friends who are not HIV-positive.

Participants offered the following comments about available services:

- The main reason people do not come into care is that they do not need services yet (they are not sick enough) and/or they do not perceive they are at risk.
- There are no barriers to mental health counseling and drug treatment. Title II and Title III pay very well for those services. But they are beginning to decrease the level of services available—instead of weekly therapy you can only go twice a month now.

Barriers to Accessing Health Care

Participants identified barriers to accessing health care:

- Health care is a major problem. Some people drive to Omaha if they have a car. It is hard to get assistance for primary health care; two participants are settled in health care (they both have cars) and one is not (no car).
- A medical provider told one consumer that it was a "conflict of interest" to treat him/her because the medical provider worked in a Christian hospital setting and believed the consumer to be immoral.
- Participants felt that many physicians are very ignorant of HIV disease, although some of the younger doctors have more knowledge.
- Participants expressed their opinion that some physicians say they will not take Ryan White reimbursement dollars as a way around treating people with HIV disease.
- The participant with no car has only one option: to walk. While Norfolk is small, having no car limits and impairs one's ability to access services and health care.
- There are not many treatment options when the local hospital finds out you have no insurance.

Experiences of Stigma and Discrimination

Participants discussed issues related to stigma and discrimination. Some of their comments and experiences are shared below.

- One participant worked until the day s/he was diagnosed. The information got back to the participant's children before they could be told in person. "That's how this community is. Everyone knows your business almost before you do—lots of gossip."
- Stigma around HIV is high in Northeast Nebraska. People fear losing jobs, their position in social world, friends. They are concerned the information will destroy family structure and lead to actual shunning.
- One of the consumers told a story about interacting with the local police: A friend had an outstanding warrant. For some reason, the police picked them up. When the police officer found out that the consumer was HIV-positive, the officer made the consumer put on gloves and a mask, sprayed him/her down from head to toe with Lysol, and asked if s/he spit or sneezed in the police car. The consumer asked to use the restroom but was not allowed access. Instead, while the policeman transported the consumer back to where s/he was picked up, he stopped the car and allowed the consumer to urinate in the woods. No other option was provided.
- Northeast Nebraska is very religious. Churches for the most part will not work with the HIV community to help plan World AIDS Day. "They give us 15 minutes on the agenda if we get in at all."
- Another story was shared about an HIV-positive person wanting to start recovery who showed up to an AA meeting intoxicated. The group took the intoxicated person to the police, who disclosed his/her HIV status to the group from AA who were there to provide support.
- One Hispanic participant talked about the experience of racial harassment by White neighbors in a previous housing situation.

- Some Hispanic people will only go to the Nebraska AIDS Project office for testing when no clients are present, other than someone who is Hispanic who can help translate. Although the results of testing are kept very confidential and generally people do not worry about confidentiality, meeting participants indicated that perceptions about that among the Hispanic population are different.
- Children of an HIV-positive parent are harassed because others believe they will catch HIV from the children. Other children and their parents disparage the character of the HIV-positive parent simply because of his/her HIV status.
- One landlord learned that a participant was HIV-positive because a picture of his/her child appeared in a newspaper as part of a story about a camp for children who were affected by HIV disease. The family was evicted shortly thereafter.

Recommendations for HIV/AIDS Housing

Participants were asked to share their priorities and recommendations for HIV/AIDS housing. The following comments were offered:

- Participants noted that people do not live in Northeast Nebraska if they are chronically homeless and living with HIV. "Most of us are housed and just need help paying our rent."
- Participants had a lengthy discussion about the impact of providing HIV/AIDS-dedicated housing and expressed the clear opinion that the community would not accept such housing. "If you build something or dedicate AIDS units it will not work." They suggested providing rental assistance and short-term rent, mortgage, and utility assistance only.

Lincoln

April 4, 2003

Participant Demographics and Background

Gender Identification: 2 men

Racial Identification: Both White/Caucasian

Housing Situation

Participants introduced themselves and described their housing histories since learning of their HIV status.

- One participant was diagnosed in 1985. At that time he was living in his partner's home in Omaha. The participant moved a number of times—between apartments, in-patient alcohol and drug treatment housing, and partner's house. His partner passed away in the mid-90s and the client bought his own home. In 2000, the participant moved to Lincoln to live with and take care of his parents. His health is not great but he is able to live independently at this point. He has good disability from his previous work, full health insurance, and pays no rent.
- One participant was diagnosed in 1990 while living out-of-state with friends. Over the next twelve years moved back and forth between Lincoln and the out-of-state location. Over this time, his partner died, and other friends were also lost to the disease. In 2002, he moved back to Lincoln to stay for good. Has been on permanent disability for many years due to a disability that he has had since birth. His rent is $295 per month, and the unit is substandard. He lives with his cats.

Additional comments about living in Lincoln:

- There are two bars in Lincoln. They are boring and uninteresting to the participants.
- Without having family in Lincoln, neither participant would choose to live there. There are no hate crime laws in Nebraska. One client had been mugged twice for being around an area known for cruising.

Need for Housing and Related Assistance

Participants discussed issues related to housing stability, including challenges they had in the past and assistance that they needed to stay in housing:

- One client lives in a building that is 90 years old and has never been updated. There are constant leaks from the kitchen and bathroom. Although the house is substandard, he has no knowledge of or mechanism to connect to fair housing or city housing inspectors—would not know how to begin.
- It's hard to get disability; it takes several months to qualify.
- One participant has Medicare and private insurance and the other participant is on Medicare. Neither had problems with obtaining health care.
- There are few transportation options: one participant owns a car and the other participant walks everywhere.
- One is physically able to work but does not want to. The other is able to work only one day a week. He volunteers at NAP but finds that there is not much need for him because so few consumers access NAP.

Participants offered the following comments about services that are available to community members:

- Nebraska AIDS Project offers limited case management. Most things have to go through Omaha or the state. Sometimes financial assistance is provided. One consumer was not aware that financial assistance was available.
- Participants would like to see a day activity center in Lincoln like the Watanabe Center in Omaha. "There is nothing to do here, no socialization." The participants described occasions of going to the NAP office just to talk, but the doors were locked and no one was there.
- A group for gay men has begun meeting once per week at a church. There are three to ten people who show up regularly.
- There is a group for HIV-positive people that is happening once per month. Only three to four people attend that meeting.
- There is counseling available. Neither participant was sure that they wanted to access that resource.

Experiences of Stigma and Discrimination

Participants discussed issues related to stigma and discrimination. Some of their comments and experiences are shared below.

- Stigma exists in many ways. Some professionals are fearful of losing their position in society and their job. One participant has a good friend who was fired as a cook once the restaurant learned he had HIV. People fear harassment.
- So many people are scared about the disease. Increased education is needed.

Recommendations for HIV/AIDS Housing

Participants were asked to share their priorities and recommendations for HIV/AIDS housing. The following recommendations were offered:

- One of the participants would like there to be an AIDS-dedicated home. He did some research on the Internet and found they have programs like that in New Orleans or San Diego. The only place an AIDS-dedicated home would work would be Lincoln or Omaha.
- Affordable low-income housing that is safe and decent is needed. Most of the Section 8 housing is scary and difficult to live in for fear of your HIV status becoming known.
- Need help obtaining better housing. Much of the better housing is affordable only with rental assistance.

Scottsbluff

April 9, 2003

People living with HIV/AIDS came together in Scottsbluff over lunch. Most people shared information about their housing histories and needs individually with the facilitator, rather than in a group. To protect the confidentiality of those who participated, information about all participants is presented together.

Participant Demographics and Background

Gender Identification: 4 men and 1 woman

Racial Identification: 4 White/Caucasian and 1 Hispanic

Housing Situation

Individuals described their housing histories since learning of their HIV status.

- One participant owned a home when s/he found out about status. Was divorced and moved multiple times to different rentals attempting to get better places each time. Utility costs and household expenses prevented the participant from being able to afford housing. Currently living with parents, and if parents were not a resource could live with a friend. If money were not a problem, participant would be living on his/her own.
- Participant had been living with his/her mother due to mental health issues. Moved to Scottsbluff area after receiving HIV diagnosis. Currently receives housing in exchange for work.
- Participant was renting a home when HIV was diagnosed and still lives in the same place. Works full time and earns too much to qualify for assistance. However, with children it can be difficult to meet expenses. Would not need to try to access utility support if the house could be weatherized and the furnace repaired.
- Participant owns a trailer and lives with his/her child. One of the biggest challenges is paying for utilities in the "harsh months."
- Participant was receiving a Section 8 voucher when s/he was diagnosed. The management agent found out and started telling the neighbors, who became scared. The participant remained in the same housing and educated the neighbors. Children are grown. Currently lives with partner.

Participants were asked why they lived where they did. Some of the reasons shared included:

- Family
- Job
- Daughter
- Access to health care

Need for Housing and Related Assistance

Participants discussed issues related to housing stability, including challenges they had in the past and assistance needed to stay in housing:

- One small incident can throw off an entire budget. If a tire is needed for the car, the house needs a repair, or a child needs braces, a very tight budget means that housing is in jeopardy. This is very stressful.
- There is a lack of affordable housing in general. "It's hard to find a safe, decent unit." "If I had to live in my own apartment, I could not; $545 per month [disability] would not be enough to live on my own."
- Some participants report that rental unit inspectors have been known to approve units that do not meet housing quality standards because the landlord pays them off. Therefore, some people live in substandard housing.
- A participant offered a recent example of an applicant for public housing being denied housing because a family member was known to be HIV-positive.
- The geographic distance from one another and to get to health care is a challenge. Some people will not access care because they are afraid of what others will think.
- Health insurance was a challenge for focus group participants. Pre-existing conditions can block approval even for those who worked full time.
- Bills from health care are stressful. It is hard to know how one is going to pay them. One participant wondered if there was a way to get on a payment plan for medical bills that would not jeopardize housing stability.
- There is no public transportation of any kind.
- One individual was not approved for a car loan because the car dealer knew the participant was HIV-positive and was not sure s/he would live long enough to pay off the loan.

Participants offered the following comments about services that are available to community members:

- Mental health services are not available.
- Chemical dependency services are available but are not "good enough."

Experiences of Stigma and Discrimination

Participants discussed issues related to stigma and discrimination. Some of their comments and experiences are shared below.

- In a small town, what others know and what they do not know is always in question. You have to be careful. "People may know you have HIV and you're never sure how or what they know or how they are going to treat you."
- It is easier to be out as a gay person than to be out as an HIV-positive person. "Too much judgment."
- Gay people are discriminated against.
- If you are known to be HIV-positive people assume you are gay, if you are gay people assume you are HIV-positive.

- People have various concerns. They wonder, "what if they (a) don't hire me, (b) treat my kids poorly, (c) don't let me rent from them," etc. Action has been taken against people because others "thought" they were HIV-positive. In work settings it is not really safe to talk about HIV status.
- In one rural community, the sheriff came and shot the dog of a gay, HIV-positive person just to show how much he didn't want the couple around. This was many years ago, "But things haven't changed that much."
- One participant has been making presentations about and has been open about his/her HIV status for eleven years. S/he also has Hepatitis C and talks about that. Because of his/her networks, s/he can present in high schools and colleges. His/her presentations do not address condoms, but also do not remain solely abstinence-based.
- Condom distribution would still be a "big no-no" and would not be possible without major controversy.
- Any outreach or access that exists is there because of a network of people who know one another.
- One participant felt that it is easier for women to be HIV-positive than men.
- If you were an involved community member before you became HIV-positive, it is easier to circulate and have people aware of your status.
- There are many who are passive about communicating or treating their HIV disease. Some of the participants in the focus group receive calls from these people to get information and to talk. In essence, it is an informal phone support system.
- Participants talked about inconsistencies and disconnects in how people treat and interact with those living with HIV disease. For example, office workers are attentive to other diseases, such as cancer, or the problems faced by families with an ill child, but HIV would "horrify" work colleagues. Some participants talked about a local "cruise" park frequented by some, including area leaders who are not perceived in their public lives as accepting of people who are gay or have HIV disease. The result is that HIV disease seems to remain invisible.
- One participant felt that Scottsbluff offers a very "Christian" moralistic environment.

Recommendations for HIV/AIDS Housing

Participants were asked to share their priorities and recommendations for HIV/AIDS housing. The following recommendations were offered:

- Respectable, safe, sanitary, and economical housing in residential settings.
- HIV complex will not work under any circumstances.
- "Rental assistance to live where I want to live."

North Platte

April 10, 2003

One individual attended the focus group held in North Platte. To protect this person's confidentiality, the summary is not included here. However, his/her input has been incorporated into the "Consumer Focus Groups Findings" section of the plan.

Kearney

April 11, 2003

Participant Demographics and Background

Gender Identification: 4 men and 1 woman

Racial Identification: All White/Caucasian

Housing Situation

Participants introduced themselves and described their housing histories since learning of their HIV status.

- One participant was diagnosed in 1990. At that time was living in an apartment in another state with a partner, and lived in various apartments over the next year and a half. After a split with his/her partner, was not able to obtain own apartment because disability income was low and ex-partner had rented all the other units. All of the landlords wanted to know why the participant was on disability. Finally got into public housing and was doing well for about two years, even though income after rent was only $100 per month. Met someone and moved to Nebraska and lives with that person. Lives in substandard housing that is provided by family.
- Participant was diagnosed in 1984 in a southern state. Split with partner after the diagnosis. Made a number of moves over the next five years and then moved to live with family in a state neighboring Nebraska. Bought a trailer six or seven years ago and lived in the trailer in various states. Now rents a house in a very rural community. Receives $734 per month from SSDI. Utility costs are high and s/he must maintain automobile insurance to get around to doctor, etc.
- One participant found out about HIV status while living with family member and friend in substandard housing in a small town in central Nebraska. The participant became very ill and moved home to be with parents where s/he stayed for three years. The participant was able to regain health and go back to work. Currently lives with family member and friend in better housing and s/he is still able to work.
- Was living in a neighboring state when s/he found out about HIV status almost twenty years ago. A few years later split with partner and lost house and business. Went back to college to get specific training, but could not get a job because s/he could not stay well long enough. Ultimately, lived in a large city for five years and was fairly stable. In 1995 his/her AIDS doctor suggested s/he return to live with parents for the end of life. Parents helped the participant regain health. Currently lives in a central Nebraska city with partner. Between the two of them, they have a very tight budget. Each month they have approximately $50 to $100 for food. S/he reports that the SSI officer advised them to hide income so they can make it.
- The participant's spouse died unexpectedly a number of years ago. One sexual encounter in the years following led to HIV infection. Lives with extended family and has received support from his/her landlord. Works at a local business, which has been reasonably supportive about his/her status. Is not eligible for Medicaid and is not taking any HIV medications. Cannot afford to take medications for other medical conditions.

Participants also discussed reasons they live in Nebraska:

- "It's cheap. I can get a two-bedroom house for $200 a month."
- "It's better than Oklahoma or Wyoming."
- Family, financial, and emotional support: "I need all of that to meet the bills and survive."

- "Can't afford to move."
- "Don't want to die alone."

Need for Housing and Related Assistance

Participants identified services that they needed in order to stay in housing:

- One participant remarked that s/he had never been afraid of HIV status or being gay before moving to Nebraska. "Now I'm petrified because of the reactions, violence, and ignorance that is pervasive."
- People feel a great deal of stress from living in fear, short of money, and frightened about what people know.
- Availability of appropriate housing is a particular concern in rural communities. Many houses do not qualify for Section 8 vouchers. The reasons are varied, including: they were built many years ago, are large, have not had updates, etc.
- One participant is very open about status. His/her life has been threatened and people shun him/her. One woman drives by and yells: "Go to church."
- It is a financial challenge to live on disability. Some have spent periods of time without medications because they could not afford the co-pay. One participant had the phone disconnected because it was that or cable and s/he chose cable.
- "How do you get a job with income and still keep your Medicaid? We need more knowledge about that."
- One financial need that is unexpected can throw a person off for a long time. It might take a year to get caught up again.
- There is concern about treatment even among medical personnel. In one small town, a physician said, "We don't have the knowledge and don't want to obtain it."
- "My physician is 170 miles away."
- Medicaid requires that a person "spend down" their monthly income in order to qualify for assistance. "What can we spend down when we are barely making it now?"
- All places you go for medical care turn medical bills over to collection agencies, which end up garnishing your wages and ruining your credit.
- One participant was depressed and felt strained by bills from doctor. S/he tried to commit suicide. Now, there are more bills from the ambulance and emergency room. "I can't get the antidepressants because I have no insurance."
- Participants have various health insurance situations: two receive Medicaid, one receives Medicare, one receives both Medicaid and Medicare, and one has no insurance at present. Three receive HIV medical care at the clinics held in Grand Island or North Platte, one goes to Lincoln for health care, and one receives care from a local medical center.

Participants offered the following comments about services that are available to community members:

- They need more than pills, doctors, rent, and utilities. "Why can't we have more case management and alternative forms of support and treatment like in other parts of the country: acupuncture, massage therapy, things to help us handle stress."

Experiences of Stigma and Discrimination

Participants discussed issues related to stigma and discrimination. Some of their comments and experiences are shared below.

- One participant found bullet holes in his windshield, dents in his car, and was jumped and told that as a "faggot" he should be dead. This person lives in an extremely small town.
- People assume there is an absolute relationship between being gay and being HIV-positive. It is hard to have many straight friends because the latter's friends assume they are gay and/or have HIV if they are friends with a gay person.
- "It's really 50-50. Some people know and don't care and the other group would just as soon we were dead."
- These are small communities. In larger communities it is a bit easier to be more open.
- The younger generation seems able to be more open. One participant had the experience of a teenage high school student out him/herself in front of the participant and a teacher. But this was a very unusual experience.
- HIV in general is not on most people's radar screen—they don't want to know.
- Gossip in small towns carries everything through town: people know names, relationships, where you live, with whom, what you buy, and what you do with your time.
- Medications come through the mail and the postal worker wants to know what they are.
- Discrimination is rampant.

Recommendations for HIV/AIDS Housing

Participants were asked to share their priorities and recommendations for HIV/AIDS housing. The facilitator described various housing options; participants in the group expressed support for various options in the following order:

- Short-term rent, mortgage, and utility assistance
- Long-term rental assistance
- Mixed-use facility development
- Single-family units spread throughout the community
- Funding for the rehabilitation of units where people currently live; providing support through existing programs to assist people where they currently live
- Vouchers in addition to what might be available through the HOPWA program; specifically, housing that allows more flexibility in screening. One participant was denied Section 8 because high medical bills ruined his/her credit.

In addition, participants:

- Supported the idea of a rural resident housing advocate who could help solve a variety of problems
- Agreed that there should be no HIV-dedicated buildings in rural communities

Appendix VI: Financing Sources for Affordable Housing

This section contains information and resources on financing affordable housing.

The following information is intended to provide an introduction to some sources of financing for affordable housing. Housing Opportunities for Persons with AIDS (HOPWA) is a U.S. Department of Housing and Urban Development funding source dedicated for people living with HIV/AIDS. Because housing is expensive to develop and operate, especially when enriched with support services, and because people living with HIV/AIDS may have very little income available to pay for rent and services, HOPWA funds alone are not sufficient to develop and operate housing. Other sources of funding are required. People living with HIV/AIDS who have low incomes are eligible for mainstream programs for low-income people. Depending on the individual, they may also be eligible for programs for people with disabilities, for people who are homeless, and others. The following is not an exhaustive list, but highlights some of the larger programs and those most directly related to housing people living with HIV/AIDS. More information and resources on financing affordable housing are available through the AIDS Housing of Washington website, (www.aidshousing.org).

U.S. Department of Housing and Urban Development (HUD) Consolidated Plan Programs

HUD requires a single, consolidated submission process, including all of the planning, application, and performance assessment documentation for the following formula programs:

- Community Development Block Grants (CDBG)
- Emergency Shelter Grants Program (ESGP)
- HOME Investment Partnerships Program (HOME)
- Housing Opportunities for Persons with AIDS (HOPWA)

The planning process is intended to help local jurisdictions develop a vision for housing and community development and to coordinate their activities. Local governments develop the plan in consultation with public and private agencies that provide supportive housing and social and health services, community members, and neighboring localities. The Consolidated Plan must indicate the activities that will be carried out in the coming year to address emergency shelter and transitional housing needs, homelessness prevention, the transition to permanent housing and independent living, and services for people who are not homeless but have supportive housing needs.

Information about each of the programs follows.

Community Development Block Grant (CDBG)

CDBG program funds may be used in a variety of ways to support community development, including the acquisition, construction, and rehabilitation of public facilities and housing. However, communities are not required to include housing when determining how they would like to use CDBG funds.

All CDBG-funded activities must address one of the three national objectives of the program:

1. Benefit people with low- and moderate-incomes.
2. Eliminate or prevent slums or blight.
3. Meet other urgent community development needs, where existing conditions pose a serious and immediate threat to the health and welfare of the community, and no other financial resources are available.

Emergency Shelter Grants Program (ESGP)

The ESGP funds are designated to improve the quality of existing emergency shelters and transitional housing for homeless people, to help create additional emergency shelters, to pay for certain operating and social service expenses in connection with homeless shelters, and for homeless prevention activities.

The HOME Investment Partnerships Program (HOME)

Communities have the flexibility to use HOME funds for the housing activities that best meet local needs and priorities. Uses can include property acquisition, rehabilitation, site improvements, demolition, new construction, and tenant-based rental assistance. Assistance can take the form of loans, advances, equity investments, interest subsidies, and others. A portion (at least 15 percent) of HOME funds must be set aside for community housing development organizations (CHDOs), which are nonprofit organizations meeting certain HUD-established criteria.

Housing Opportunities for Persons with AIDS (HOPWA)

HOPWA is another program that comes under the Consolidated Plan process. HOPWA provides grant funds to state and local governments to design long-term, comprehensive strategies for meeting the housing needs of low-income people living with HIV/AIDS and their families. Participating jurisdictions have the flexibility to create a range of housing programs, including housing information services, resource identification, project- or tenant-based rental assistance, short-term rent, mortgage, and utility payments to prevent homelessness, housing and development operations, and support services. Ninety percent of HOPWA funds are awarded through formula grants, and the remaining 10 percent are awarded through a competitive grant program.

HOPWA Formula Grants

HUD awards 75 percent of HOPWA Formula Grant funds to eligible states and qualifying cities. Eligibility is based on the number of cases of AIDS reported by the Centers for Disease Control and Prevention as of March 31 of the year prior to the appropriation. Eligible metropolitan statistical areas (EMSAs) and states receive direct allocations of HOPWA funding when 1,500 cumulative cases of AIDS are diagnosed in a region. The remaining 25 percent of funds is allocated among metropolitan areas that have had a higher than average per capita incidence of AIDS.

HOPWA grantees may carry out eligible programs themselves, deliver them through any of their administrative entities, select or competitively solicit project sponsors, and/or contract with service providers.

HOPWA Competitive Grants

Competitive grants are awarded in the following categories:

- **Special Projects of National Significance (SPNS)**. These projects are intended to be models for addressing the needs of low-income people living with HIV/AIDS and their families because of their innovation or ability to be replicated.
- **Long-Term Comprehensive Strategies for Providing Housing and Related Services.** Applications in this category can be submitted by state or local governments that are not eligible for HOPWA formula allocations during that fiscal year.

Homeless Assistance Continuum of Care

In order to encourage the integration and coordination of community homeless assistance, HUD combined three major homeless assistance programs—Supportive Housing Program, Shelter Plus Care, and Section 8 Moderate Rehabilitation Program Single Room Occupancy Program (SRO)—under the Continuum of Care planning and allocation process.

The Continuum of Care system includes four components: outreach to and needs assessment of individuals or families who are homeless, emergency shelters with supportive services, transitional housing with support services, and permanent independent or support housing to meet long-term needs. The establishment of a Continuum of Care system involves a community-wide or region-wide process involving nonprofit organizations (including those representing persons with AIDS and other disabilities), government agencies, other homeless providers, housing developers and service providers, private foundations, neighborhood groups, and homeless or formerly homeless individuals. It is very important for applicants to understand that funding for the Supportive Housing Program, Shelter Plus Care, and Section 8 SRO projects must be applied for within the context of the Continuum of Care process.

Supportive Housing Program (SHP)

SHP program funds are used to provide supportive housing, either as transitional housing for homeless people or permanent housing for homeless people who have disabilities, including people living with HIV/AIDS. In addition, SHP funds can also be used for safe havens, which provide specialized permanent housing for severely mentally ill homeless persons who have been unwilling to participate in support services, support services for people not living in supportive housing, and other innovative supportive housing models. SHP funds can be used for a range of activities from land acquisition to administrative expenses.

Shelter Plus Care

The Shelter Plus Care program provides rental assistance for permanent housing, linked with support services funded by other sources, to homeless and disabled people and their families. Activities under Shelter Plus Care include tenant-based rental assistance, project-based rental assistance, sponsor-based rental assistance, and Section 8 moderate rehabilitation assistance for single room occupancy dwellings.[1]

Section 8 Moderate Rehabilitation Single Room Occupancy Dwellings (SRO)

Under the SRO program, HUD contracts with public housing authorities (PHAs) to enable the moderate rehabilitation[2] of residential properties that, when completed, will contain multiple single room dwelling units. The PHAs make rental assistance payments to the landlords on behalf of the homeless individuals who rent the rehabilitated dwellings, covering the difference between a portion of the tenant's income (normally 30 percent) and the HUD-established Fair Market Rent (FMR) of the unit. The program does not provide financing for the rehabilitation work, but a portion of this cost is reflected in the rent.

Other HUD Programs

HUD has many other programs, but three are particularly relevant when developing housing for people living with AIDS: Supportive Housing for Persons with Disabilities (Section 811), Section 8 Rental Assistance, and Section 8 Housing Opportunities for Persons with Disabilities (Mainstream Program).

Supportive Housing for Persons with Disabilities (Section 811)

Nonprofit organizations can use Section 811 funds to construct, acquire, and/or rehabilitate supportive housing for very low-income persons with disabilities, including those with disabilities resulting from HIV-infection. The support services should address the residents' individual needs, provide optimal independent living, and provide access to the community and employment opportunities.

Section 811 funding is provided in two parts: a one-time capital advance, essentially a grant, to fund development, and ongoing project-based rental assistance, that pays the difference between the tenant payment and the operating cost.

Section 8 Rental Assistance Programs

Section 8 Rental Assistance takes the form of certificates and vouchers which are administered by public housing authorities. Rental certificates and vouchers allow income-eligible households to find and obtain rental housing independently. Tenants typically pay 30 percent of their income, while the certificate or voucher pays the difference, up to the HUD-established Fair Market Rent (FMR) for the area. The primary difference between certificates and vouchers is that with a voucher, a tenant can pay more than 30 percent of their income if the cost of the unit exceeds the FMR.

Public housing authorities can also designate up to 15 percent of their vouchers to be project-based in new construction or rehabilitated housing. Project-based vouchers stay with a particular unit, so that income-

[1] This differs from the Section 8 SRO program described next. Specifically, Shelter Plus Care SRO targets people who are homeless *and* have a disability, and Shelter Plus Care projects must include support services, while Section 8 SRO residents must be able to live independently.

[2] HUD considers moderate rehabilitation to be a minimum of $3,000 of rehabilitation work per unit.

eligible tenants can come and go, but the unit stays affordable. Tenants cannot take the vouchers away from the unit for use elsewhere.

Section 8 Housing Opportunities for People with Disabilities (Mainstream Program)

In FY 1997, HUD moved a portion of the funds originally earmarked for the Supportive Housing for Persons with Disabilities (Section 811) to create this separate tenant-based program. This provides certificates and vouchers to persons with disabilities to allow for more housing choice.

Low Income Housing Tax Credits

Created in 1986, the Low Income Housing Tax Credit allows qualified owners of or investors in eligible low-income rental housing to reduce their federal income taxes on a dollar-for-dollar basis for a ten-year period, subject to compliance. Low-income housing developers use these credits to attract investors, who commit to funding a project in return for the tax credit.

Dollars of tax credit available are allocated to states based on population, equal to $1.75 per capita in 2002 and adjusted for inflation thereafter. States administer their own competitive process for the credits. The Low Income Housing Tax Credit has become the primary federal resource for developing low-income housing. Tax credits funded approximately 1.2 million units through 2001, and contribute to the development of approximately 67,000 additional units per year.[3]

USDA Rural Development, Rural Housing Services

The Rural Housing Service (RHS) of the United States Department of Agriculture (USDA) Rural Development provides a number of home ownership and rental opportunities for rural Americans. These programs provide a wide range of assistance, from direct loans to very low-, low-, or moderate-income households to buy or renovate existing housing to funding organizations to provide technical assistance to low- and very low-income households seeking to build their own homes in rural areas. Organizations eligible to apply for RHS funds include local and state government entities, associations, non-profit groups, and Federally recognized Native American groups. Funds are also available to communities for construction of essential facilities, such as hospitals, vocational rehabilitation centers, and public transportation, and to organizations needing to prepare sites with infrastructure, such as roads and sewage facilities.

[3] The Danner Company, *The Low Income Housing Tax Credit Program.* Available online: www.danter.com/taxcredit (Accessed: October 7, 2003).

Appendix VII: HIV/AIDS Housing Continuum

The housing needs of people living with HIV/AIDS cover a wide range, from one-time emergency utility assistance to nursing home care. Consequently, it is useful to think about housing opportunities along a continuum. The following text reviews each of the housing types in the HIV/AIDS housing continuum and offers ideas for addressing needs in each area.

It is important to understand that the wide range of housing needs for people living with HIV/AIDS and their families does not exist apart from other housing needs in a community. Generally, HIV/AIDS housing needs fall into an overall, community-wide housing continuum. This continuum, which provides a comprehensive way of evaluating a community's resources, divides housing needs and resources into the following categories, each of which is explained in detail in this section:

Emergency ↔ Transitional ↔ Permanent ↔ Specialized Care

Many of the best housing resources for people living with HIV/AIDS are provided by mainstream organizations that serve a wide variety of people. It is usually faster, cheaper, and more appropriate to draw on mainstream housing resources than to create new facilities and services just for people living with HIV/AIDS. Training other providers to understand the special needs of people living with HIV/AIDS can provide the same result as, and often more efficiently than, providing a new service tailored to specific needs. One effective strategy is to encourage mainstream housing providers to meet the needs of people living with HIV/AIDS through a range of nondevelopment mechanisms.

Emergency Housing Assistance

Emergency housing assistance is one-time or very short-term assistance provided to address an immediate housing crisis—often for people who are homeless or at imminent risk of becoming homeless. The primary goal of emergency assistance is to solve the immediate housing crisis; the assistance is usually one of the following:

- Emergency rent, mortgage, or utility payments to prevent loss of residence
- Hotel/motel vouchers
- Emergency shelter

Assistance to Remain in Your Home: Rent, Mortgage, or Utility Payments

Emergency housing assistance can be structured to specifically help households facing a crisis that could result in displacement from their housing. This assistance may take the form of a rent or mortgage payment or utility assistance, and may also include emergency repairs, weatherization, and other assistance that would forestall eviction, foreclosure, or uninhabitability of the residence. It is designed to address one-time crises, not ongoing needs. AIDS service organizations can administer this type of emergency assistance program directly or can contract with mainstream providers of similar services. Assistance with rent or mortgage payments can also be provided on a transitional or permanent basis, both of which are described under "Tenant-Based Transitional Assistance" and "Tenant-Based Rental Assistance" on the following pages.

When rent, mortgage, or utility payments work best: This type of assistance is most effective in communities where it is more likely that the financial crises faced by people living with HIV/AIDS can be

overcome with short-term assistance. It is especially useful where a large percentage of those in housing need are homeowners, as is the case in most rural areas. Since it is much less expensive to keep people in their homes than to find or develop new ones, this can be a cost-effective form of assistance.

Advantages

- Preserving existing housing is much easier than developing new housing options.
- Multiple households can be served with less funding.
- Emergency housing payments are made just once or twice to each household and can be easy to administer.
- Remaining in his or her own home is the preferred choice of many people living with HIV/AIDS.

Disadvantages

- Many people living with HIV/AIDS need ongoing financial assistance, rather than short-term assistance, to remain in their homes.
- Emergency assistance does not result in long-term affordable housing units that will be available to people in need in the future.
- This approach does not address the needs of people who are homeless.

Hotel or Motel Vouchers

Hotel or motel vouchers are a form of emergency assistance given to homeless households that have no other alternative but living on the streets or in a substandard or inappropriate housing situation. Typically, vouchers are coordinated through case managers and provide homeless households with a motel room for a week at a time, with a maximum stay of about a month. Voucher providers negotiate agreements with local hotels or motels, and the hotels or motels bill the providers as rooms are used. Hotels or motels may offer discounted rates to nonprofit organizations.

When hotel or motel vouchers work best: Vouchers may be the only emergency housing option for small, rural communities that do not have enough homeless people to support the development and operation of a shelter. Vouchers may also be the best emergency option for people who are too sick to stay in an emergency shelter or for families who may not be able to stay together in a shelter. Hotel or motel vouchers work best when the local waiting lists for affordable housing are relatively short, and people are likely to have a place to transition to relatively quickly.

Advantages

- Vacant hotel or motel rooms can usually be found immediately.
- This approach does not require the creation of any new housing resources.
- Hotel or motel vouchers can be simpler to administer; the administering agency is not responsible for managing a facility.

Disadvantages

- Hotel or motel vouchers can be an expensive way to provide temporary housing.
- Many hotels and motels will not agree to participate in voucher programs.
- Most hotels and motels do not offer cooking facilities, or refrigeration for medications.
- Individual members of families do not have privacy in hotel or motel rooms.

- Many hotels and motels used for this purpose are located in neighborhoods with drug trafficking and other criminal activities.
- Hotel or motel vouchers are not a long-term housing solution.

Emergency Shelter

Emergency shelter is basic, temporary, overnight sleeping accommodation. Stays at emergency shelters are often limited to less than 30 days. Emergency shelter can take any form; beds in dormitory-style rooms or mattresses on the floor of space that has a different daytime use (for example, church assembly room, public office building) are common examples. Some shelters offer private rooms for families, and many also provide a meal program. Typical shelter providers include community action agencies, the Salvation Army, and other faith-based service agencies.

When emergency shelters work best: Emergency shelters are best suited for population centers with a significant homeless population and numerous affordable transitional and permanent housing options. If a community has a significant homeless population and no emergency shelters, AIDS service organizations should work with other homeless service providers to assess whether local need would justify the development of a shelter. In communities with emergency shelters, an HIV/AIDS training program for shelter staff can help the existing resources to address the needs of people living with HIV/AIDS more effectively.

Advantages

- Emergency shelters offer an immediate response to housing crises.
- Many communities already have existing emergency shelters.
- Shelters are often cost-effective to operate.
- Shelters are often the first point of contact with services for the newly homeless.

Disadvantages

- The large numbers of people served, combined with conditions that may be unsanitary, encourage the spread of infectious diseases in shelters.
- Emergency shelters often require people to go elsewhere during the day, which can be a hardship for people living with HIV/AIDS.
- The shared living situation of most emergency shelters offers little confidentiality for people living with HIV/AIDS.
- Emergency shelters typically do not have accessible refrigerated storage for prescription medications or offer private bathroom facilities for managing health care needs.
- Mainstream shelter providers may lack sensitivity to issues faced by people living with HIV/AIDS.
- Few shelters are designed to accommodate families.
- Emergency shelter is not a permanent solution to housing problems.

Transitional Housing Assistance

Transitional housing assistance is of limited duration—usually from 30 days to 2 years—and is intended to help people transition from a housing crisis into a permanent, stable housing situation. Its goal is to provide temporary housing and services to help households develop the skills and locate the ongoing resources they need to succeed in permanent housing. Additionally, people with no or poor rental history can build a

positive rental history while in transitional housing, increasing their access to permanent housing. Transitional housing assistance is effective where consumers are likely to either become self-sufficient or transition to another permanent housing resource by the time it ends. Transitional housing assistance most often includes:

- Assistance with move-in and occupancy needs
- Tenant-based transitional housing
- Supportive transitional housing project

Assistance with Move-In and Occupancy Needs

Move-in/occupancy needs assistance encompasses anything that assists households in overcoming the one-time challenges of establishing a new residence. Typical assistance includes providing moving expenses, rent deposit, move-in kit (linens, cookware, dishes, flatware, cleaning supplies), furniture, appliances, utility hook-up fees, and basic life skills training. Move-in/occupancy needs assistance can be either in-kind assistance or cash payments.

When move-in and occupancy needs assistance works best: In communities in which homeless people are transitioning into permanent housing, a program to provide move-in and occupancy needs assistance is essential. Since all homeless people have similar move-in and occupancy needs, centralized assistance programs that are coordinated with other homeless service providers generally work the best.

Advantages

- Move-in assistance can be relatively inexpensive.
- These programs are easy to administer.
- Move-in and occupancy needs assistance can be donated or provided by volunteers.
- Local businesses may be willing to donate to these programs.

Disadvantages

- Many people living with HIV/AIDS need more than just move-in and start-up assistance.
- Where rent deposits are provided, they are often retained by landlords as cleaning fees or kept by departing tenants.

Tenant-Based Transitional Housing Assistance

Some communities offer tenant-based rental assistance programs on a transitional basis. These function much like the programs described under "Assistance to remain in your home" above, but offer housing assistance for a longer period of time than just one or two payments. These programs are often developed under the guidelines of the Housing Opportunities for Persons with AIDS (HOPWA) program for short-term, 21-week assistance, but may also provide housing assistance for as long as 2 years.

When tenant-based transitional housing assistance works best: These programs work best in communities where consumers will be able to transition to permanent housing assistance within the established time limit.

Advantages

- Tenants have more choices of housing location.
- Tenants can use this type of assistance in existing housing units; new units do not need to be developed.
- This type of assistance can prevent a person from becoming homeless while waiting to access permanent assistance.
- Tenant-based programs can be implemented relatively quickly.
- Tenant-based transitional housing assistance program operation is comparatively less complex than developing and operating a facility-based program.

Disadvantages

- Tenant-based programs do not create new long-term housing resources. The community has this resource only as long as funding continues to be available (unlike developing new permanent housing units).
- This type of program may not be appropriate for people who need more support services in order to remain housed successfully.
- Some landlords are unwilling to rent to people with housing assistance vouchers.
- Some communities do not have enough good-quality rental units available at Fair Market Rent levels.

Supportive Transitional Housing

Supportive transitional housing is temporary housing combined with support services designed to assist homeless families and individuals to overcome the problems that led to their homelessness and return to living in permanent, independent housing. The services provided through a transitional program may address substance use, mental health, life skills training, education, and family support, and may help establish relationships between consumers and service providers. Supportive transitional programs can also help people who have been incarcerated to reintegrate into the community.

Transitional housing is typically provided in a centralized facility, but it may also be provided in scattered sites. Since the transitional needs of homeless people living with HIV/AIDS are similar to those of other homeless people, HIV/AIDS service organizations can collaborate with mainstream transitional housing providers. See "Master Leasing" for information about another method for providing transitional housing.

When supportive transitional housing works best: Supportive transitional housing is most helpful in communities that have a significant homeless population, and is successful only when all of the necessary support services are funded and in place. Since transitional housing is intended to move people into successful permanent housing placements, it works best in communities that have a sufficient supply of affordable permanent housing to accommodate those moving out of the transitional program. Smaller, rural communities should focus on providing permanent housing opportunities before developing transitional housing.

Advantages

- People leaving good transitional programs are much more likely to maintain stability in permanent housing.
- Transitional models often require program participation and compliance as conditions of residency, which gives service providers leverage to ensure that tenants benefit from the services in the program.

Disadvantages

- The support services necessary for a good transitional program are expensive to provide.
- Transitional programs are not successful in areas that lack adequate affordable permanent housing options; people leaving transitional housing must be able to find permanent housing at the end of the transitional period.

Permanent Housing Assistance

The goal of permanent housing assistance is to create safe, stable, and decent housing opportunities. Permanent housing assistance includes any of the following:

- Support services designed to help people live independently, provided on an ongoing basis
- Tenant-based rental assistance
- Shallow rent subsidy (another form of tenant-based rental assistance)
- Provision of actual housing units through sponsor- or project-based assistance, including through:
  - Lease buy-downs
  - Set-asides in larger housing projects
  - Scattered-site condominium acquisition
  - Group homes/shared housing
  - Independent apartment development projects

Support Services

In some circumstances, an array of support services may be all that is necessary to stabilize people living with HIV/AIDS in permanent housing. Support services are most often offered as a complement to a housing situation; without ongoing support services, many people living with HIV/AIDS risk losing their housing. Services can include case management, home care, counseling, nutrition and meal services, crisis intervention, legal assistance, transportation, day health programs, mental health services, and substance use treatment services, and may be provided by an AIDS service network or through other service providers.

When support services work best: A range of support services is needed in every community, regardless of the adequacy of housing options. Support services should be an integral part of every housing solution. Where the local supply of affordable housing is adequate to meet the demand, ongoing support services may be all that is necessary to ensure stable, successful housing. The local AIDS service organization should have the capacity to serve people in their homes and should develop good referral arrangements with other service providers.

Advantages

- Support service provision can help tenants remain in their existing home.
- Neither capital funding nor a time-consuming development process is necessary.
- Existing providers in the community can partner and contribute their skills and knowledge.
- Local volunteer teams can provide many HIV/AIDS services.

Disadvantages

- People with extremely low incomes often require financial assistance in addition to support services in order to find and keep housing.
- Providing support services to people in widely scattered locations can be expensive.
- Securing funding for ongoing services is a challenge.

Tenant-Based Rental Assistance

Tenant-based rental assistance (TBRA) is ongoing assistance paid to a tenant (or his or her landlord) to cover the difference between market rents and what the tenant can afford to pay. Tenants find their own units and may continue receiving the rental assistance as long as their income remains below the qualifying income standard. Many TBRA programs are federally subsidized, administered by local public housing authorities, and governed by HUD's Section 8 regulations. Some are funded by other sources, such as HOPWA, or operated by AIDS service organizations and nonprofit agencies. Section 8 regulations require all units with Section 8 tenants to meet federal housing quality standards (HQS), and the subsidy levels are set at the difference between HUD's annually established Fair Market Rent for the appropriate unit size and 30 percent of the tenant's household income.

Many communities have established TBRA programs with HOPWA funds, which are often structured similar to Section 8. However, HOPWA, unlike Section 8, allows for local discretion regarding serving undocumented immigrants and people with criminal histories. Shallow rent subsidies are another form of tenant-based rental assistance, and are discussed below.

When TBRA works best: Tenant-based rental assistance programs work best when there is a partnership between an experienced local (or regional) housing authority willing to administer the subsidy, and an AIDS service organization willing to market the subsidies, prescreen tenants, and assist tenants in finding appropriate units. Where this partnership exists, TBRA can be effective in communities of any size. TBRA is best suited for communities with a surplus of units renting at or below Fair Market Rent levels, or renting for a relatively affordable price.

Advantages

- Tenants may choose where they live.
- Tenants pay only 30 percent of their income to rent.
- Tenants can use TBRA in existing housing units.
- TBRA programs can be implemented relatively quickly.
- TBRA programs can be implemented statewide, allowing for coverage of rural areas with few housing assistance providers.
- Some local housing authorities give Section 8 waiting-list preference to people with terminal illnesses or who have HOPWA rental assistance.
- TBRA programs do not require the same level of technical skills as housing development, and can therefore be more accessible to an AIDS service organization.

Disadvantages

- TBRA programs do not create new long-term housing resources. The community has this resource only as long as funding continues to be available (unlike developing new permanent housing units). When the funding runs out, existing tenants lose their subsidy and, potentially, their housing.
- Some landlords are unwilling to rent to people with TBRA vouchers.

- Often, available units that are both within the FMR cost limit and operated by property managers willing to accept TBRA are located in neighborhoods with drug trafficking and other criminal activities.
- Federal subsidies are subject to annual renewal.
- Funding for many other TBRA programs is limited to 3 to 5 years and can be very difficult to renew.
- Some communities do not have an adequate supply of good-quality rental units at Fair Market Rent levels.

Shallow Rent or Mortgage Subsidies

Shallow rent or mortgage subsidies are another way of providing assistance to a tenant. Instead of calculating the consumer contribution and benefit provided based on the tenant's income, however, shallow rent or mortgage subsidies are based on a smaller, fixed amount. For example, a program might provide $100 to $200 per month toward rent or mortgage payments, and the consumer would cover the remainder of monthly housing costs.

When shallow rent subsidies work best: Shallow rent or mortgage subsidies work best where consumers are close to being able to afford housing costs independently, and regularly need a small amount of assistance. Mortgage assistance is particularly helpful in areas where many consumers are homeowners, which is often the case in rural areas. Shallow rent or mortgage subsidies also work best where housing costs are staying fairly level; in an increasing-cost housing market, this kind of program can become ineffective or excessively costly.

Advantages

- Tenants may choose where they live.
- Tenants can often use shallow rent subsidies in order to remain in their current home.
- A larger number of people can be served when a lesser amount of assistance is needed for each.
- Shallow rent subsidy programs can be implemented relatively quickly.
- Shallow rent subsidy programs do not require the same level of technical skills as housing development, and can therefore be more accessible to an AIDS service organization.

Disadvantages

- Shallow rent subsidy programs do not create new long-term housing resources. The community has this resource only as long as funding continues to be available (unlike developing new permanent housing units).
- Shallow rent subsidies are inappropriate for people who need more assistance to remain stably housed.

Set-Asides in Other Housing Projects

Because of the time, energy, complexity, and risk involved in developing affordable housing, AIDS housing organizations should take on new development projects only after careful consideration of other available options. One of the best ways to secure affordable units without development is by negotiating set-asides for people living with HIV/AIDS in projects developed by affordable housing providers. This may be as simple as a referral agreement or may involve the contribution of capital (see lease buy-downs) or the negotiation of a master lease (see master leasing) to help lower rents. In the latter cases, the AIDS housing organization must find additional funding.

In exchange for the investment of public subsidy, affordable housing developers make a commitment to keep the housing affordable for the long term, usually 30 to 50 years. A project-based set-aside involves a housing developer or owner dedicating a specified number of units to serve a special needs population for a defined term, up to the life of the project. The AIDS housing provider and property manager establish terms for the set-aside in a legal agreement.

When housing set-asides work best: Set-asides work best in projects that are developed with rents already affordable to people living with HIV/AIDS. When this is not the case, AIDS housing organizations are most likely to interest mainstream housing developers in set-asides when they can bring a source of debt-free funding into the project that otherwise would not be included (for example, HOPWA). This additional funding allows the housing developer to reduce the amount of repayable financing and lower rents by lowering debt service requirements.

Advantages

- The burden of developing, owning, and managing housing is borne by experienced developers with property management capacity.
- Set-asides can ensure access to affordable housing more quickly than undertaking a new development project.
- If agreements are properly negotiated, set-asides can secure long-term commitments.
- Economies of scale are not required: a set-aside is economically efficient with even a single unit.
- Residents can integrate into the community.
- Setting aside some units for people living with HIV/AIDS may increase the competitiveness of the housing developer's funding applications.

Disadvantages

- Mainstream housing providers may have rules that disqualify the people who need assistance.
- Some areas lack housing providers willing to set aside units for people living with HIV/AIDS, and some providers, particularly housing authorities, have rules that preclude setting aside units for specific populations.
- Set-asides are effective only when the rent on the units is affordable to the people you want to serve.
- The need for affordable rental units in some areas is so great that housing providers may not be willing to enter into special set-aside agreements.
- AIDS housing providers need to make certain that the physical design of the units will meet the needs of their residents, and that property management staff will work well with the people living with HIV/AIDS who are to receive housing assistance.

Lease Buy-Downs

Buying down a lease is a way of securing long-term affordability without the obstacles and worries of housing development and ownership. In a lease buy-down, an AIDS service organization or other housing provider enters into a long-term lease agreement with a property manager, and establishes a rent reserve fund which will pay the difference between the market rent and the amount that residents can pay.

The rent reserve is funded at the outset at a level that will last through the term of the lease. The payment amount is calculated by taking the net present value of the difference between the tenant's rental income stream and the rental income stream required to sustain the unit. The term of the lease, the discount factor used to determine net present value, and the basis for the affordable rents are all matters of negotiation

between the AIDS housing organization and the mainstream housing provider. The AIDS housing organization must provide the up-front payment from capital funding sources.

When long-term leases work best: When the existing affordable rents in a community are not affordable for a person living with HIV/AIDS, lease buy-downs may be the solution. Lease buy-downs work best in communities with mainstream housing providers or landlords who are willing to engage in long-term leases. These deals are most common between housing providers and AIDS housing organizations that have good, existing relationships. When a mainstream housing provider offers rents that are already affordable to the targeted population, a set-aside agreement (see set-asides) may be preferable to a long-term lease.

Advantages

- Long-term affordability is assured without ongoing rent subsidy.
- AIDS service organizations do not have to manage the property.
- Economies of scale are not required: leasing even a single unit can be economically efficient.
- Residents can integrate into the community, unlike when living in a facility solely dedicated to people living with HIV/AIDS.

Disadvantages

- Developing contractual agreements can be complicated, time consuming, and expensive.
- Some funders are uncomfortable participating in a project with a long-term lease; many prefer ownership.
- It may be difficult to find property managers willing to enter into a long-term lease.
- Some communities have very few rental housing units available.
- If the rent differential is large, the cost of a lease buy-down may be high.
- Mainstream housing providers may have rules that disqualify the people you wish to assist.
- Different funding sources require different commitment periods (up to 51 years).

Master Leasing

Master leasing can be used to provide either transitional or permanent housing. Using this strategy, the AIDS housing provider leases units—individually, as single-family homes, on a floor, or throughout an entire building—that are then leased at an affordable cost to people living with HIV/AIDS. Master leasing is typically for a shorter term than lease buy-downs (above), but should be for at least 5 years, if possible.

When master leasing works best: Master leasing works best in communities with an active market in residential rental properties in healthy neighborhoods. Support services should also be available that can meet the needs of residents in the leased location(s).

Advantages

- AIDS housing providers can secure units quickly with master leasing.
- Community acceptance issues can often be avoided by pursuing this strategy.
- Residents can integrate into the community.

Disadvantages

- An operating subsidy will likely be necessary for each unit for the term of the lease.
- Available, affordable properties are often in neighborhoods with drug trafficking and criminal activities.
- If it is necessary to displace residents in a building to be leased, relocation can be complicated and expensive.
- The condition of a leased building needs to be assessed carefully, and staff may be needed to handle interior maintenance issues.
- The lack of a centralized support-service space can be problematic.
- Staff need to cultivate and maintain relationships with the landlord.

Scattered-Site Acquisition

Acquiring scattered-site condominiums or single-family homes is a way for AIDS housing organizations to enjoy some of the benefits of ownership, with reduced management responsibilities. In this scenario, AIDS housing organizations raise capital funding to purchase condominiums or single-family homes in their community and lease the units to people living with HIV/AIDS.

When scattered-site acquisition works best: Scattered-site acquisition works best in communities that have an active market in affordable condominiums or single family homes, and where support service networks can deliver a range of services to widely dispersed populations.

Advantages

- Acquisition provides quick access to units, when compared to development.
- Scattered condominium sites can effectively meet scattered demand.
- In some communities, acquiring new condominiums is less expensive than building new apartment buildings with public money.
- A small number of units can be developed efficiently.
- The property management functions of the AIDS housing provider are minimized.
- Residents are integrated into the community.

Disadvantages

- Condominium homeowner associations may exercise control over leases, tenants, and the number of renters allowed in a development, and the AIDS housing provider needs to have staff that can manage relations with a homeowner association.
- Although homeowner associations cover general maintenance for the exterior of the property, the AIDS housing provider will need to handle complicated property management responsibilities, including tenant screening, rent collection, general maintenance of the unit, and unit turnover, across scattered sites.
- Many smaller communities do not have any condominium developments.
- Condominiums have monthly maintenance fees as well as special or emergency assessments over time, and these need to be planned for.
- Acquired housing may require ongoing operating subsidy to keep rents affordable.
- Condominiums offer less control than more traditional ownership.
- Some public lenders are wary of condominium acquisition.

Group Homes or Other Shared Housing Arrangements

Group living assistance can include anything from a group home owned by an AIDS housing organization to a housemate referral service. Many of the early HIV/AIDS housing projects were shared single-family houses, but high vacancy rates in such facilities in recent years due to medical advances in treating HIV have shifted the focus of new developments to independent units. A group home or other shared housing can either be purchased or leased by the AIDS housing organization.

In many areas, small group homes can be developed in single-family zones, which are more prevalent than multifamily zones. However, each community has its own land use laws that restrict the number of unrelated adults that may live together, and it is important to comply with local regulations. Group homes also require ongoing maintenance and attention to being a good neighbor in order to be successful.

When group homes work best: Group living situations are best in those communities where consumer preference surveys indicate sufficient demand for this type of accommodation. While group homes may be less expensive to operate when full than independent living units, empty beds can make them more expensive. Similarly, the costs of providing accompanying support services to people in need of mental health and/or substance use treatment services can exceed the cost savings of group housing.

Advantages

- Group homes can be less expensive to develop and operate than independent apartments.
- Community living provides supports to people living with HIV/AIDS.
- Group homes offer churches or civic organizations the opportunity to participate in HIV/AIDS housing by sponsoring individual rooms in a house.

Disadvantages

- Consumer surveys of people living with HIV/AIDS often indicate a preference for independent units over shared accommodations.
- If local demand for shared housing drops, it is very difficult to convert part of a shared house to a new use.
- Personality conflicts between housemates can be difficult to manage, especially when the residents have mental health and/or substance use issues.
- Some people are reluctant to live in an HIV/AIDS-only housing project.
- Confidentiality can be hard to maintain in a group living situation.
- Proper nutrition may not be maintained if the sponsor does not take some responsibility for assuring meal provision.

Independent Apartment Development Projects

Independent apartment projects can be developed by HIV/AIDS housing organizations specifically to meet the permanent housing needs of people living with HIV/AIDS, or to serve a mixed population that includes people living with HIV/AIDS. AIDS housing organizations can function as the developer, owner, manager, and service provider for the units, or they may contract out those functions to other, experienced organizations. The tasks involved in project development include researching the need, developing a program, acquiring a site, assembling an architectural and engineering team, raising capital financing, hiring a contractor, overseeing construction, renting-up the units, and beginning operations. A development project typically lasts 2 to 4 years, and the complexity of the project is usually determined by the size of the development and the mix of financing.

When independent apartment projects work best: Independent apartment projects work best in communities with a sufficiently large demand for HIV/AIDS housing units. AIDS housing organizations in communities with few people living with HIV/AIDS should consider master leasing, a lease buy-down, set-aside units, or scattered-site condominiums. Inexperienced housing developers should partner with experienced developers before undertaking a new development project because of the many skills and technical knowledge required.

Advantages

- Housing units can be developed to address specific needs.
- People with HIV/AIDS usually prefer independent apartment units to shared accommodations.
- Large development projects can increase an organization's capacity to raise private donations and grants.
- Project development creates long-term housing resources.
- Projects offer opportunities for AIDS service organizations to work with organizations that address other community service needs.
- This model offers the owner the most control.

Disadvantages

- Developing an independent apartment project is very expensive, complex, and time-consuming.
- Multifamily-zoned land can be hard to find in some areas.
- An AIDS housing project can attract community opposition.
- The number of units required to operate a building efficiently may be larger than the local demand for AIDS housing.
- Development projects may require ongoing operating subsidy to keep rents affordable for people with extremely low incomes.
- Some people are reluctant to live in an AIDS-only housing project.
- Development requires a long-term commitment to housing operation.

Specialized Care Facilities

Specialized care facilities include short- and long-term housing combined with services designed to assist people whose medical or behavioral health make independent living impossible. Specialized care facilities range from assisted living to skilled nursing to hospice care. Each of these facilities targets only a portion of people living with HIV/AIDS in a community, those with very specific medical or support service needs. All of these facilities can be either limited to those with HIV/AIDS or open to all whose support needs are similar. Although mainstream specialized care providers may not initially be equipped to serve those living with HIV/AIDS, spending time and money to adapt these mainstream resources is usually the fastest and most efficient way to address the specialized care needs of people living with HIV/AIDS as opposed to creating new facilities.

When specialized care facilities work best: Specialized care facilities work best in communities where there is a large concentration of people living with HIV/AIDS who require higher-end care. Because specialized care requires complex technical skills in both the provision of care and business management, and because it is highly regulated, specialized care facilities work best when an experienced specialized care provider is a partner.

Advantages

- Specialized care facilities can provide a high level of care for people whose medical or behavioral health does not allow them to live independently.

Disadvantages

- The need for skilled staffing makes specialized care facilities very expensive to operate.
- People who are living longer typically do not want to live in a group living situation if it can be avoided.
- Maintaining a specialized care facility for people living with HIV/AIDS is only possible in areas with a large concentration of people living with HIV/AIDS.

Appendix VIII: Glossary of HIV/AIDS- and Housing-Related Terms

This glossary includes terms used in the plan and terms related to HIV/AIDS and housing.

AFFORDABLE HOUSING Housing is generally defined by the U.S. Department of Housing and Urban Development as affordable when the occupant is paying no more than 30 percent of their adjusted gross income for housing costs, including utilities. Affordable housing may refer to subsidized or unsubsidized units.

AIDS Acquired Immunodeficiency Syndrome. A person with HIV infection is diagnosed with AIDS when either a) they develop an opportunistic infection defined by the Centers for Disease Control and Prevention as an AIDS indication, or b) on the basis of certain blood tests related to the immune system.

ASSISTED LIVING Group residences that offer the delivery of professionally managed personal and health care services, including meals, 24-hour attendant care, social activities, assistance with bathing, dressing and transferring, dispensing medication, and health monitoring. Assisted living is intended for those who need some assistance in performing the activities of daily living but who do not need the high level of medical supervision provided by a skilled nursing facility. Assisted living facilities may be HIV/AIDS-specific, or they may serve people with many needs.

ASYMPTOMATIC HIV INFECTION Without symptoms. Usually used in the HIV/AIDS literature to describe a person who has a positive reaction to one of several tests for HIV antibodies but who shows no clinical symptoms of the disease.

AT RISK OF BECOMING HOMELESS Being on the brink of becoming homeless due to one or more of the following: having inadequate income or paying too high a percentage of income on rent (typically 50 percent or more), living in housing that does not meet federal housing quality standards, or living in housing that is seriously overcrowded. Also see Homeless Person.

BEDS The unit of measure when describing the overnight sleeping capacity or availability for shelters, skilled nursing facilities, hospices, board and care, adult family living, assisted living, and other such facilities.

CDC The Centers for Disease Control and Prevention, the lead federal agency for protecting health and safety. CDC serves as a national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities.

CASE MANAGEMENT The central component of HIV/AIDS care is case management. Case managers coordinate all the care a client receives from all providers in the community. Typically, case management services are provided by agencies separate from the housing providers. When a case management client resides in a residence, however, the residential staff members have the most frequent contact with the resident and often are responsible for the care coordination. Case management is also provided through other social service systems.

COMMUNITY DEVELOPMENT BLOCK GRANT PROGRAM (CDBG) A federal grant program, administered by the U.S. Department of Housing and Urban Development, authorized under Title I of the Housing and Community Development Act of 1974 and administered by state and local governments. CDBG funds may be used in various ways to support community development, including acquisition, construction, rehabilitation, and/or operation of public facilities and housing.

CONSOLIDATED PLAN A document written by a state or local government and submitted annually to the U.S. Department of Housing and Urban Development that serves as the planning document of the jurisdiction and an application for funding under any of the community planning development formula grant programs (Community Development Block Grant, Emergency Shelter Grant, HOME Investment Partnerships Program, and Housing Opportunities for Persons with AIDS). The document describes the housing needs of the low- and moderate-income residents of a jurisdiction, outlining strategies to meet the needs and listing all resources available to implement the strategies.

CONTINUUM OF CARE An approach that helps communities plan for and provide a full range of emergency, transitional, and permanent housing and service resources to address the various needs of homeless persons. The approach is based on the understanding that homelessness is not caused merely by a lack of shelter, but involves a variety of underlying, unmet needs—physical, economic, and social. Designed to encourage localities to develop a coordinated and comprehensive long-term approach to homelessness, the Continuum of Care consolidates the planning, application, and reporting documents for the U.S. Department of Housing and Urban Development's Shelter Plus Care, Section 8 Moderate Rehabilitation Single-Room Occupancy Dwellings (SRO) Program, and Supportive Housing Program.

DEVELOPMENTAL DISABILITY Referring to a variety of disabilities which impact cognitive functioning and learning style. Sometimes referred to as mental retardation.

DISCRIMINATION Treating a person differently because they belong to, or are perceived to belong to, an identifiable group. Often discrimination is due to a person's being from a different race, country, or religion, or because they're female, have a family, are older, disabled, or are gay or lesbian.

DUALLY DIAGNOSED See Multiply Diagnosed.

EMA OR EMSA Eligible metropolitan (statistical) area. Geographic area based on population and cumulative AIDS cases, to receive federal funds through the Ryan White CARE Act and Housing Opportunities for Persons with AIDS (HOPWA) Program.

EMERGENCY HOUSING ASSISTANCE Emergency housing assistance is one-time or very short-term assistance provided to address an immediate housing crisis—often for people who are homeless or at imminent risk of becoming homeless. The primary goal of emergency assistance is to solve the immediate housing crisis. The assistance is usually one of the following: emergency rent, mortgage or utility payments to prevent loss of residence, motel vouchers, and/or emergency shelter.

EMERGENCY SHELTER Any facility with overnight sleeping accommodations, the primary purpose of which is to provide temporary shelter for the homeless in general or for specific populations of homeless persons.

EMERGENCY SHELTER GRANTS PROGRAM (ESGP) A federal program administered by the U.S. Department of Housing and Urban Development that provides funds to local governments to help provide additional emergency shelters or improve the quality of existing emergency shelters and to help meet operating costs of essential social services to homeless individuals. Funds are provided to grantees through both a formula-based process for eligible metropolitan areas and urban counties and through a national competition for non-formula-eligible counties.

EXTREMELY LOW-INCOME An individual or family whose income is between 0 and 30 percent of the median income for the area, as determined by the U.S. Department of Housing and Urban Development.

FAIR HOUSING ACT The Federal Fair Housing Act prohibits, among other things, the owners of rental housing from discriminating against potential tenants based on race, sex, national origin, disability, or family size.

FAIR MARKET RENT (FMR) Rents set by the U.S. Department of Housing and Urban Development (HUD) for a state, county, or urban area that define maximum allowable rents for HUD-funded subsidy programs. HUD calculates FMR to be at the 40th percentile of recent moves, excluding apartments built within the past two years, meaning that 40 percent of recent movers paid less, and 60 percent paid more.

FAMILY For purposes of the plan and local policy interpretation, and in keeping with HOPWA regulations, the term "family" encompasses nontraditional households, including families made up of unmarried domestic partners. A family is a self-defined group of people who may live together on a regular basis and who have a close, long-term, committed relationship and share responsibility for the common necessities of life. Family members may include adult partners, dependent elders, or children, as well as people related by blood or marriage.

FEDERAL EMERGENCY MANAGEMENT ADMINISTRATION (FEMA) An independent agency reporting to the President and tasked with responding to, planning for, recovering from, and mitigating disaster. FEMA administers the Emergency Food and Shelter Program as mandated by Title III of the McKinney-Vento Act. Also see McKinney-Vento Act.

GROUP HOUSING/SHARED LIVING Two or more single adults, or families with children, sharing living arrangements in a house or an apartment. Generally, individuals each have a bedroom and share a kitchen, bath, and housekeeping responsibilities. The group facility may provide a limited range of services and be licensed or unlicensed.

HAART Highly Active Anti-Retroviral Therapy. The preferred term for potent anti-HIV treatment. This means a combination of drugs (usually three or more) to combat HIV. Usually more than one class of drug is included in a HAART regimen. Includes protease inhibitors, and is often referred to as combination therapy or the "cocktail."

HARM REDUCTION A set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies for safer use, from managed use to abstinence. Harm reduction strategies meet drug users "where they're at," addressing conditions of use along with the use itself.

HIV Human Immunodeficiency Virus. The virus that causes AIDS. HIV disease is characterized by a gradual deterioration of immune functions. During the course of infection, crucial immune cells, called CD4+ T cells, are disabled and killed, and their numbers progressively decline. People infected with HIV may or may not feel or look sick.

HOME HOME Investment Partnerships Program. A program administered by the U.S. Department of Housing and Urban Development providing grants for low-income housing through rental assistance, housing rehabilitation, and new construction.

HOMELESS PERSON According to the U.S. Department of Housing and Urban Development, a homeless person is an individual or member of a family who 1) lacks a fixed, regular, and adequate night-time residence, or 2) has a primary night-time residence that is a) a publicly supervised or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); b) an institution that provides a temporary residence for individuals intended to be institutionalized; c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. Individuals paying more than 50 percent of their income for housing are also considered at such high risk for homelessness that they are included in the definition of homeless for some federal programs. The term "homeless individual" does not include any individuals imprisoned or otherwise detained under an act of federal or state law.

HOPE VI HOPE VI, or the Urban Revitalization Program, a program administered by the U.S. Department of Housing and Urban Development, funds rehabilitation and/or replacement of distressed public housing units and support services. Through the end of FY 2001 the program has awarded $4.8 billion to 146 communities in 37 states since 1993.

HOPWA Housing Opportunities for Persons with AIDS. A U.S. Department of Housing and Urban Development program which pays for housing and support services for people living with HIV/AIDS and their families. Created by an Act of Congress in 1990.

HOSPICE A support and care provided to people in the last phases of a terminal illness so that they may live as fully and comfortably as possible. Hospice focuses on alleviating pain and discomfort, improving the quality of life, and preparing individuals mentally and spiritually for their eventual death.

HOUSING COST BURDEN The extent to which gross housing costs, including utility costs, exceed 30 percent of gross income, based on data published by the U.S. Census Bureau.

HOUSING COST BURDEN, SEVERE The extent to which gross housing costs, including utility costs, exceed 50 percent of gross income, based on data published by the U.S. Census Bureau.

HOUSING UNIT An occupied or vacant house, apartment, or a single room (SRO housing) that is intended as separate living quarters.

HOUSING QUALITY STANDARDS (HQS) Standards set by the U.S. Department of Housing and Urban Development (HUD) to ensure that all housing receiving HUD financial assistance meets a certain level of quality. HQS requires that recipients of HUD funding provide safe and sanitary housing that is in compliance with state and local housing codes, licensing requirements, and any other jurisdiction-specific housing requirements.

HRSA Health Resources and Services Administration. HRSA is an agency of the U.S. Department of Health and Human Services that works toward providing health care to low-income, uninsured, isolated, vulnerable, and special needs populations through a number of programs including: Ryan White CARE Act, Rural Health Initiative, and other community-based health initiatives.

HUD U.S. Department of Housing and Urban Development. HUD is a cabinet-level agency designed to advocate for the housing needs of people with low incomes through programs for public housing, special needs housing, and first time homebuyers.

INFORMATION AND REFERRAL Assistance to individuals who are having a difficult time finding and/or securing housing.

LOW-INCOME FAMILY Family whose income does not exceed 50 percent of the median income for the area, as determined by the U.S. Department of Housing and Urban Development (HUD), with adjustments for smaller and larger families. HUD may establish income ceilings higher or lower than 50 percent of the median for the area on the basis of findings that such variations are necessary because of prevailing levels of construction costs or Fair Market Rents, or unusually high or low family incomes.

LOW INCOME HOUSING TAX CREDIT PROGRAM Formula allotment of federal income tax credits administered by states and distributed to nonprofit and for-profit developers of and investors in low-income rental housing. Since its creation in 1986 by the Tax Reform Act, more than a million units have been funded nationwide, utilizing the equivalent of more than $3 billion dollars in funding annually.

MASTER LEASING A housing strategy in which a sponsor agency leases housing units from private or nonprofit housing landlords and subleases the units to individuals and families that meet the sponsor agency's eligibility criteria. This housing option is used mainly as transitional housing. In a transitional housing master leasing scenario, subleases with individuals and families can include stipulations for duration of tenancy and responsibilities of tenancy, such as a requirement to participate in support services.

MCKINNEY-VENTO ACT The primary federal response targeted to assisting homeless individuals and families. The scope of the Act includes: outreach, emergency food and shelter, transitional and permanent housing, primary health care services, mental health, alcohol and drug abuse treatment, education, job training, and child care. There are nine titles under the McKinney-Vento Act that are administered by several different federal agencies, including the U.S. Department of Housing and Urban Development (HUD). McKinney-Vento Act Programs administered by HUD include: Emergency Shelter Grant Program, Supportive Housing Program, Section 8 Moderate Rehabilitation for Single-Room Occupancy Dwellings, Supplemental Assistance to Facilities to Assist the Homeless, and Single Family Property Disposition Initiative. Also see: Emergency Shelter Grants, Federal Emergency Management Administration, Shelter Plus Care, Section 8 Moderate Rehabilitation for Single-Room Occupancy Dwellings, and Supportive Housing Program.

MEDIAN FAMILY INCOME (MFI) The amount, as determined by HUD, which divides an area's income distribution into two equal groups, one having incomes above this amount, one having incomes below. MFI is based on the most recent U.S. Census family income data and is adjusted annually for inflation. HUD and the U.S. Census Bureau consider a family to be a household comprised of related individuals. For example: A family is a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.

MEDICAID A program jointly funded by the states and the federal government that provides medical insurance for people who are unable to afford medical care. The program focuses mainly on the needs of the elderly, people with disabilities, and children.

MEDICARE A federal program under the Social Security Administration that provides health insurance to the elderly and disabled.

MENTAL ILLNESS A serious and persistent mental or emotional impairment that significantly limits a person's ability to live independently.

MODERATE INCOME An individual or family whose income is between 50 percent and 80 percent of the median income for the area, as determined by the U.S. Department of Housing and Urban Development (HUD), with adjustments for smaller or larger families. HUD may establish income ceilings higher or lower than 80 percent of the median for the area on the basis of findings that such variations are necessary because of prevailing levels of construction costs or Fair Market Rents, or unusually high or low family incomes.

MULTIPLY DIAGNOSED To be diagnosed with HIV/AIDS and also have histories of other disabilities. This term generally refers to people who are HIV-positive and have chronic alcohol and/or other drug use problems and/or a serious mental illness. The terms "dually diagnosed" and "triply diagnosed" are also used.

OPERATING COSTS (in relation to housing) Distinct from capital costs and support services costs. Operating costs include property taxes, insurance, maintenance, and repair.

PERMANENT HOUSING Housing which is intended to be the tenant's home for as long as they choose. In the supportive housing model, services are available to the tenant, but accepting services cannot be required of tenants or in any way impact their tenancy. Tenants of permanent housing sign legal lease documents.

PERSON WITH A DISABILITY HUD's Section 8 program defines a "person with a disability" as: a person who is determined to: 1) have a physical, mental, or emotional impairment that is expected to be of continued and indefinite duration, substantially impedes his or her ability to live independently, and is of such a nature that the ability could be improved by more suitable housing conditions; or 2) have a developmental disability, as defined in the Developmental Disabilities Assistance and Bill of Rights Act.

PROJECT-BASED RENTAL ASSISTANCE Rental assistance that is tied to a specific unit of housing, not a specific tenant. Tenants receiving project-based rental assistance give up the right to that assistance upon moving from the unit. Also see Rental Assistance, Shallow Rent Subsidy, and Tenant-based Rental Assistance.

PROTEASE INHIBITORS A group of anti-retroviral medications for people living with HIV/AIDS. Protease inhibitors act by preventing the replication of HIV in the body and are often prescribed in combination with other HIV medications. Also see HAART.

RENTAL ASSISTANCE Cash subsidy for housing costs provided as either project-based rental assistance or tenant-based rental assistance. HOPWA short-term rental assistance is available for up to 21 weeks. HOPWA long-term rental assistance is provided for longer than 21 weeks. Due to HOPWA regulations, rental assistance cannot be guaranteed for longer than three years. Ryan White funds can be used for short-term, transitional, or emergency housing defined as necessary to gain or maintain access to medical care. Also see Project-based Rental Assistance, Tenant-based Rental Assistance, and Shallow Rent Subsidy.

RYAN WHITE CARE ACT Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. A program of the Health Resources and Services Administration (HRSA) providing funds for health care and supportive services for people living with AIDS. Created by an Act of Congress in 1990. Also see HRSA.

SCATTERED-SITE HOUSING Individual units scattered throughout an area, such as condominiums and single family homes in different complexes or neighborhoods, creating dispersed and integrated housing options.

SECTION 8/HOUSING CHOICE VOUCHER PROGRAM A federal program operated by local housing authorities providing rental assistance to low-income persons and administered by the U.S. Department of Housing and Urban Development. Under the Section 8/Housing Choice Voucher Program, the local housing authority determines a standard amount of rental assistance an individual or family will receive. The tenant would pay the difference between the amount of assistance and the actual rent, which may require the tenant to spend more than 30 percent of their income on rent. The Section 8/Housing Choice Voucher Program is a tenant-based program, meaning the subsidy is specific to the tenant as opposed to the unit.

SECTION 8 HOUSING OPPORTUNITIES FOR PERSONS WITH DISABILITIES (MAINSTREAM PROGRAM) The Mainstream Program, created in 1997 and administered by the U.S. Department of Housing and Urban Development, utilizes up to 25 percent of the funds originally earmarked for Section 811 to a separate tenant-based rental assistance program for persons with disabilities. Also see Section 811.

SECTION 8 MODERATE REHABILITATION FOR SINGLE-ROOM OCCUPANCY DWELLINGS This program provides Section 8 rental assistance for moderate rehabilitation of buildings with SRO units (single-room occupancy dwellings). The program, administered by the U.S. Department of Housing and Urban Development, is designed for the use of an individual person. Units often do not contain food preparation or sanitary facilities. A public housing authority makes Section 8 rental assistance payments to the landlords for the homeless people who rent the rehabilitated units.

SECTION 811 Provides grants to nonprofit organizations for acquisitions, new construction, and/or rehabilitation of rental housing with support services for very low-income persons with disabilities. The program is administered by the U.S. Department of Housing and Urban Development and includes a capital advance and project-based rental assistance payments.

SHALLOW RENT SUBSIDY Short-term or ongoing cash subsidy for housing costs provided as either project-based rental assistance or tenant-based rental assistance. Typically, shallow subsidies are for a set amount and are not related to the percentage of income paid to rent. Also see Project-based Rental Assistance, Rental Assistance, and Tenant-based Rental Assistance.

SHELTER PLUS CARE A national grant program administered by the U.S. Department of Housing and Urban Development providing rental assistance, linked with support services, to homeless individuals who have disabilities (primarily serious mental illness, chronic substance abuse, and disabilities resulting from HIV/AIDS) and their families.

SKILLED NURSING FACILITY A nursing home or facility providing 24-hour care from nurses and aides.

SRO Single-Room Occupancy. Refers to studio apartments which provide very limited cooking facilities and typically have shared bathrooms. They are often in rehabilitated hotels, and can be used for emergency, transitional, or permanent housing.

SOCIAL SECURITY DISABILITY INSURANCE (SSDI) A federal government benefit for individuals who are medically disabled and have worked for enough years to be covered under Social Security.

SPECIAL NEEDS HOUSING Housing for people who require specific accommodations and/or support to access and maintain housing. Special needs housing may target the elderly; the disabled, including people living with HIV/AIDS; and those with histories of homelessness, mental illness, and substance use issues.

SUBSIDIZED RENTAL HOUSING Assisted housing (see glossary definition) that receives or has received project-based governmental assistance and is rented to low- or moderate-income households. Subsidized rental housing does not include owner-occupied units, nor does it include Section 8 certificate/voucher holders in market-rate housing.

SUBSTANCE USE ISSUES The problems resulting from a pattern of using substances such as alcohol and drugs. Problems can include: a failure to fulfill major responsibilities and/or using substances in spite of physical, legal, social, and interpersonal problems and risks.

SUPPLEMENTAL SECURITY INCOME (SSI) SSI is a federal government benefit for individuals who are 65 or older, or blind, or have a disability and earn a low income.

SUPPORTIVE HOUSING Housing, including housing units and group quarters, which include on- and off-site support services.

SUPPORTIVE HOUSING PROGRAM (SHP) Provides grants to develop housing and related support services for people moving from homelessness to independent living. Program funds help homeless people live in a stable place, increase their skills or income, and gain more control over the decisions that affect their lives. Funding may be used for capital costs, facility operations, and support services.

SUPPORT SERVICES Services provided to individuals to assist them to achieve and/or maintain stability, health, and improved quality of life. Some examples are case management, medical or psychological counseling and supervision, child care, transportation, and job training.

SYMPTOMATIC HIV INFECTION Any perceptible, subjective change in the body or its functions that indicates disease or phases of disease, as reported by the patient. When referring to a person who is HIV-positive, this indicates a person who is sick and/or shows medical symptoms of the disease, but does not have an AIDS diagnosis.

TANF Temporary Assistance for Needy Families, a program administered by the U.S. Department of Health and Human Services. TANF, which replaced and is sometimes referred to as welfare, provides assistance and work opportunities to families with low incomes by granting states the federal funds and guidelines to administer their own welfare programs.

TENANT-BASED RENTAL ASSISTANCE A form of rental assistance in which the assisted tenant may move to a different housing unit while maintaining their assistance. The assistance is provided for the tenant, not a specific housing unit. Also see Project-based Rental Assistance, Rental Assistance, and Shallow Rent Subsidy.

TRANSGENDER Individuals whose sense of gender identity does not match their physiological sex, including those who have changed or are in the process of changing their sex from male to female or female to male.

TRANSITIONAL HOUSING A project that is designed to provide housing and appropriate support services to homeless persons to facilitate movement to independent living within 24 months, or a longer period approved by the U.S. Department of Housing and Urban Development (HUD). For purposes of the HOME program, there is not a HUD-approved time period for moving to independent living.